TITLE 22

INSURANCE CODE

Title 22 Revision Effective January 1, 2009—Acts 2008, No. 415

Acts 2008, No. 415, § 1 amended and reenacted Title 22 of the Louisiana Revised Statutes of 1950, the Louisiana Insurance Code, effective January 1, 2009. Act 415 directed the Louisiana State Law Institute to redesignate the provisions of Title 22, formerly comprised of R.S. 22:1 to 22:3311, into a new format and numbering scheme comprised of R.S. 22:1 to 22:2371, without changing the substance of the provisions.

See Table, ante.

Sections 2 and 3 of Act 415 provide:

"Section 2. The Louisiana State Law Institute is hereby directed to change any citations, Chapters, Parts, Subparts, or other references contained in the current provisions of Title 22 of the Louisiana Revised Statutes of 1950 or in any other Title or Code of the Revised Statutes to reflect the new citations, Chapters, Parts, Subparts, or other references found in this Act.

"Section 3. This Act shall become effective on January 1, 2009.

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 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2003, No. 135, § 1.

SUBPART A. OFFICE OF THE INSURANCE COMMISSIONER; GENERAL DUTIES AND RESPONSIBILITIES

§ 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 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.

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

D. 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.

E. The commissioner of insurance shall have the authority to make reasonable rules and regulations, not inconsistent with law, to enforce, carry out, and make effective the implementation of this Code.

Renumbered from R.S. 22:2 and R.S. 22:8(B) and (C) by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. at noon on 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; Acts 2009, No. 503, § 1.

§ 3. Composition of Department of Insurance

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 licensing, the office of financial solvency, the office of consumer advocacy and diversity, the office of health, life and annuity, the office of consumer services, the division of insurance fraud, the division of legal services, the division of public affairs, the division of diversity and opportunity 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.

Renumbered from R.S. 22:8(A) by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 473, § 1, eff. July 1, 1986. Amended by Acts 1992, No. 984, § 7; Acts 1999, No. 885, § 1, eff. June 30, 1999; Acts 2001, No. 184, § 1, eff. July 1, 2001; Acts 2009, No. 503, § 1; Acts 2013, No. 217, § 1; Acts 2015, No. 274, § 1, eff. June 29, 2015.

SUBPART B. COMPLIANCE WITH CODE REQUIRED; RULES AND REGULATIONS BY COMMISSIONER; QUALIFICATION REQUIRED

§ 11. Rules and regulations by commissioner

A. 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.

B. 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.

Renumbered from R.S. 22:3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 117, § 1; Acts 1992, No. 463, § 1; Acts 2009, No. 503, § 1.

§ 12. Insurer; qualification required; compliance with Code 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. 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.

Renumbered from R.S. 22:4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 13. 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 Subpart A of Part I of Chapter 5 of this Code, R.S. 22:1541 et seq.

Renumbered from R.S. 22:7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1979, No. 255, § 1. Amended by Acts 1992, No. 1113, § 1; Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996.

§ 14. 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 this Title 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) of this Subsection.

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 hearing under this Section shall be conducted in accordance with Chapter 12 of this Title, R.S. 22:2191 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.

Renumbered from R.S. 22:13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 1033, § 1. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 15. Repealed by Acts 2009, No. 503, § 2

§ 16. 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 commissioner of insurance pursuant to this Subpart within thirty days of the issuance thereof, the commissioner may levy and receive a fine of up to twenty-five thousand dollars. If a hearing has been requested by the insurance company or rating organization, the penalty shall not be imposed until such time as the division of administrative law makes a finding and issues an order that the penalty is warranted in a proper hearing, held in the manner provided in Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1447 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 524, § 1. Amended by Acts 1987, No. 313, § 1; Acts 1990, No. 647, § 1; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 17. 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.

Renumbered from R.S. 22:1456 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 18. Suspension or revocation of insurers' licenses; fines; orders

A. The commissioner of insurance may, as a penalty, in accordance with R.S. 49:961, refuse to renew, or may suspend, or revoke the certificate of authority or license of any insurer, person, or entity violating any of the provisions of this Code, or in lieu of suspension or revocation of a certificate or license duly issued, the commissioner may levy a fine not to exceed one thousand dollars for each violation per insurer, person, or entity, up to one hundred thousand

dollars aggregate for all violations in a calendar year per insurer, person, or entity, when such violations warrant the refusal, suspension, or revocation of such certificate or license, or the imposition of the fine. The commissioner is also authorized to order any insurer, person, or entity to cease and desist any such action that violates any provision of this Code. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq. If the insurer has demanded a timely hearing, the penalty or fine ordered by the commissioner shall not be imposed until such time as the division of administrative law makes a finding that the penalty or fine is warranted in a proper hearing, held in the manner provided in Chapter 12 of this Title.

B. The commissioner may deny, refuse to renew, suspend, or revoke any certificate of authority of any health insurer that writes a limited benefit line of health insurance or otherwise issues a health policy in the same limited benefit line in the state or for a citizen of the state within five years after it has ceased to write such limited benefit line of health insurance in the state. A limited benefit line of health insurance means a specified form of health benefit coverage as defined in R.S. 22:47(2)(c).

Renumbered from R.S. 22:1457 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2012, No. 319, § 1.

§ 19. Duration of licenses

All licenses issued to foreign or domestic insurers of any kind, including fraternal benefit societies, producers, 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.

Renumbered from R.S. 22:1458 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1964, No. 145, § 1, effective Jan. 1, 1965; Acts 2003, No. 136, § 1; Acts 2009, No. 503, § 1.

§ 20. Redesignated as R.S. 22:1566

§ 21. Agreement on producers' compensation prohibited

No insurer shall enter into any combination or agreement with another insurer to prevent its legally authorized producers and representatives in this state from accepting a higher compensation than that paid by any party or parties to such agreement.

Renumbered from R.S. 22:1452 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 22. Repealed by Acts 2009, No. 503, § 2

§ 23. 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 producer 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 producer. 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 producer.

(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 producer. 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 producer, that the insurance company renew the policy or write other insurance business.

(2) When the insurance producer has, by contract, agreed to act exclusively for one company or group of affiliated insurance companies, in which case the rights of the producer shall be determined by the terms of the producer's contract with that company or affiliated group.

(3) When the producer is in default for nonpayment of premiums or other monies due and owing for which the agent is in default under the producer'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 producer 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 producers whose contracts are not terminated.

(5) To policies providing group coverage and health insurance.

C. The producer 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. 22:18.

(2) In addition, the producer 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 producer may maintain a civil action in a court of competent jurisdiction for lost commissions.

(3)(a) All life insurance, disability income, long-term care, and annuity files, whether paper or electronic, submitted to an insurance company, are owned by the insurance company. The producer who sold the policy has the right to retain a copy of the file submitted to the issuing company. The producer has the right to retain a copy of the file after terminating his affiliation with the issuing company, unless the producer and the issuing company agree in writing that the producer shall not have such a right. Should the issuing company wish to make copies of the information retained by the producer, such copies shall be made at the issuing company's expense.

(b) This Paragraph shall not apply to any policy issued under the home service marketing distribution system referenced in R.S. 22:1962(C).

(c) As used in this Paragraph, files include all records, written or electronic, that were gathered and maintained by the producer.

(d) Notwithstanding any other provision of this Paragraph to the contrary, information a producer may retain shall not include real-time data and updates maintained on the insurance company computer system or any data protected by the Gramm-Leach-Bliley Act, 15 U.S.C. 6801-15 U.S.C. 6809, or the security laws.

(4) 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.

Renumbered from R.S. 22:1474 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1186, § 1. Amended by Acts 2008, No. 137, § 1; Acts 2009, No. 503, § 1; Acts 2012, No. 271, § 1.

§ 24. Life and health sales quotas; prohibitions

No existing contract between an insurer and a producer may be amended to add any provision that may require, as a quota, a producer 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 producer to sell life or health insurance.

Renumbered from R.S. 22:1475 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 287, § 1. Amended by Acts 2009, No. 503, § 1.

SUBPART C. EQUAL OPPORTUNITY IN INSURANCE

§ 31. Division of diversity and opportunity

A. There is hereby created within the Department of Insurance a division of diversity and opportunity 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 producers, 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 producers, and contracting for services with insurance companies.

(4) To assist members of minority groups in obtaining employment, producer 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 producers.

(6) Repealed by Acts 2015, No. 274, § 3, eff. June 29, 2015.

B. The division of diversity and opportunity may conduct a survey of insurance companies doing business in Louisiana in order to seek information and data relative to the policies and practices of hiring of and contracting with minorities. The survey, data, and responses thereto shall not be a public record as defined by the Public Records Law and shall be exempt from disclosure, except such exemption shall not apply with respect to the aggregated number of minorities hired and the positions for which they were hired.

C. The division of diversity and opportunity shall review all complaints alleging a violation of the provisions of this Subpart. Upon receipt of a complaint, the division shall notify an insurer against whom the complaint was filed of the nature of the complaint and provide the insurer with the opportunity to make a written explanation. As a part of the response, the insurer may submit to the division any affirmative action plan it may have in effect. The division shall consider any affirmative action plan and any other pertinent information submitted to it in determining whether or not the insurer has engaged in a pattern or practice of employment discrimination prohibited by Part IV of Chapter 3-A of Title 23, R.S. 23:331 et seq.

D. The division of diversity and opportunity shall report apparent violations of this Subpart to the commissioner who may commence enforcement proceedings in accordance with R.S. 22:33.

Renumbered from R.S. 22:1921 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 850, § 1. Amended by Acts 1992, No. 377, § 1, eff. June 17, 1992; Acts 1993, No. 380, § 1; Acts 1999, No. 885, § 1, eff. June 30, 1999; Acts 2009, No. 503, § 1; Acts 2013, No. 209, § 1; Acts 2015, No. 274, § 1, eff. June 29, 2015.

§ 32. Advisory Committee on Equal Opportunity

A. (1) There is hereby created within the Department of Insurance, in the division of diversity and opportunity, the Advisory Committee on Equal Opportunity. The committee shall be composed of twenty-five members. Twenty-four members shall be appointed by the governor and shall serve at his pleasure. The deputy commissioner of diversity and opportunity shall serve ex officio as the twenty-fifth member. Five 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, the Monroe 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. Seventeen 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) Property Casualty Insurers Association of America.

(g) American Insurance Association.

(h) Repealed by Acts 2009, No. 503, § 2.

(i) Louisiana Association of Health Plans.

(j) Property and casualty insurers unaffiliated with the trade associations designated in the preceding Subparagraphs.

(k) The state chapter of the Louis A. Martinet Society.

(l) Independent Insurance Agents and Brokers of Louisiana.

(m) Louisiana Realtists Association.

(n) Louisiana Black Chamber of Commerce.

(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.

(r) Greater Southwest Louisiana Black Chamber of Commerce.

(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, meals, and necessary lodging 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.

(4) For the conducting of business, a quorum shall mean a simple majority of members appointed present with no fewer than ten members present.

B. The committee shall assist the commissioner of insurance and the division of diversity and opportunity 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 producers, and contracting for services with insurance companies transacting business in Louisiana. The commissioner of insurance shall promulgate rules and regulations to implement this Subpart.

C. Repealed by Acts 2015, No. 274, § 3, eff. June 29, 2015.

D. Repealed by Acts 2015, No. 274, § 3, eff. June 29, 2015.

E. Nothing contained in this Section or in R.S. 22:31 shall be construed to expand the coverage of Part IV of Chapter 3-A of Title 23, R.S. 23: 332 et seq. for purposes of the sanctions authorized against insurers under R.S. 22:33.

Renumbered from R.S. 22:1922 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 850, § 1. Amended by Acts 1992, No. 1134, § 1; Acts 1993, No. 89, § 1; Acts 1999, No. 885, § 1, eff. June 30, 1999; Acts 2001, No. 168, § 1; Acts 2009, No. 503, § 1; Acts 2013, No. 85, § 1; Acts 2015, No. 274, § 1, eff. June 29, 2015.

§ 33. Sanctions

A. Whenever the commissioner of insurance receives notification of an apparent violation from the division of diversity and opportunity, 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 Part IV of Chapter 3-A of Title 23, R.S. 23:331 et seq., 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 Subpart shall be construed to authorize the commissioner to revoke a certificate of authority of any insurer for any violation of this Subpart.

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 Subpart 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.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1923 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 850, § 1. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2015, No. 274, § 1, eff. June 29, 2015.

§ 34. 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.

Renumbered from R.S. 22:652 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 35. 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, R.S. 49:950 et seq., 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.

Renumbered from R.S. 22:652.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 381, § 1. Amended by Acts 2009, No. 317, § 1.

SUBPART D. INSURANCE IN GENERAL

§ 41. Policyholder bill of rights

The following items exist in Louisiana statutes and shall serve as standards for a policyholder bill of rights and do not create additional causes of actions or further penalties not otherwise provided under Louisiana statutes:

(1) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable coverage in accordance with R.S. 22:1964.

(2) Policyholders shall have the right to insurance advertising that is not false and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy in accordance with R.S. 22:1964.

(3) Policyholders shall have the right to an insurance company that is financially stable.

(4) Policyholders shall have the right to be treated fairly and be free from unfair or deceptive acts or practices in accordance with R.S. 22:1961 et seq.

(5) Policyholders shall have the right to receive service from competent, honest insurance producers that will answer their questions promptly.

(6) Policyholders shall have the right to receive the appropriate disclosure form as an insert in the front of the policy that complies with R.S. 22:1319 and 1332.

(7) Policyholders shall have the right to balanced and positive regulation by the Department of Insurance.

(8) Policyholders shall have the right to check the license status of an insurance company, producer, or adjuster.

(9) Policyholders shall have the right to receive written notice of cancellation or nonrenewal at least thirty days prior to the effective date of the cancellation or nonrenewal, unless the cancellation or nonrenewal is for non-payment of premium and shall have the right to protection from improper cancellation or nonrenewal in accordance with R.S. 22:1265 and 1333.

(10) Policyholders shall have the right to receive in writing the reason for any cancellation or nonrenewal of coverage. The written statement must provide an explanation for the cancellation or nonrenewal of coverage.

(11) Policyholders shall have the right to cancel their policy and receive a refund of any unearned premium. If a policy was funded by a premium finance company, the unearned premium will be returned to the premium finance company to pay toward the policyholder's financing loan.

(12) Policyholders shall have the right to a written notification detailing any change in policy provisions at renewal.

(13) Policyholders shall have the right to receive payment of the amount of any property damage claim, or a portion of the claim, due or a written offer to settle any property damage claim within thirty days after receipt of satisfactory proof of loss in accordance with R.S. 22:1892 and 1973. If a claim is denied, policyholders shall have the right to receive a written explanation as to the reason for denial, in whole or in part, of any claim made under their policy of insurance.

(14) Relative to first party property damage claims, policyholders shall have the right to request and receive from the insurance company any estimates, bids, plans, measurements, drawings, engineer reports, contractor reports, statements or documents that are not legally privileged that the insurance company prepared, had prepared, or used during its adjustment of the policyholder's claim. A company may keep confidential adjuster notes, logs, and any documents prepared in conjunction with a fraud investigation.

(15) Policyholders shall have the right to file a complaint against any insurance company, producer, or adjuster with the Department of Insurance, and have that complaint investigated by the department.

(16) Policyholders shall have the right to a readable policy, to receive a complete property insurance policy, and to request a duplicate or replacement policy as needed.

(17) Policyholders shall have the right to the remedies provided for in R.S. 22:1892 if an insurer violates that Section in the handling of the claim.

Renumbered from R.S. 22:1455 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 222, § 2, eff. July 2, 2007. Amended by Acts 2009, No. 503, § 1.

§ 42. 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.

Renumbered from R.S. 22:2.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1304, § 1, eff. July 12, 1999. Amended by Acts 2001, No. 1032, § 8.

§ 42.1. Confidentiality of information; exceptions

A. Notwithstanding the provisions of Subsections B and C of this Section, the commissioner shall comply with the provisions of R.S. 22:43; however, no identifier listed in Subsection E of this Section of any of the following persons shall be part of the separate file, record, or report required pursuant to R.S. 22:43 when recording information about any complaint or the compilation of statistical data:

(1) The individual who is the subject of any health information, health information record, or the working papers, recorded information, documents, or copies thereof or related thereto.

(2) Anyone identified as, or who it is reasonable to believe is, a relative, employer, or household member of the individual who is described in Paragraph (1) of this Subsection, where the relative, employer, or household member is listed in any record described in Paragraph (1) of this Subsection.

B. (1) All health information in the custody of the Department of Insurance shall be confidential. No part of any health information, health information record, or the working papers, recorded information, documents, or copies thereof or related thereto, produced by, obtained by, or disclosed to the commissioner, or any other person, and in the custody of the commissioner shall be disclosed under Title 44 of the Louisiana Revised Statutes of 1950.

(2) "Health information" means any information in any form or medium, transmitted or maintained in any manner, and in the custody of the department that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care, including medications and prescriptions, to an individual, or the past, present, or future payment for the provision of health care, including medications and prescriptions, to an

individual.

C. No records, or the working papers, recorded information, documents, or copies thereof or related thereto, produced by, obtained by, or disclosed to the commissioner, or any other person, in the course of or after the resolution of a complaint against any person or entity subject to the jurisdiction of the Department of Insurance and which are in the custody of the commissioner, shall be disclosed under Title 44 of the Louisiana Revised Statutes of 1950.

D. (1) Nothing in this Section shall prohibit the communication of health information or health information records, or copies thereof, in the custody of the commissioner to:

(a) The individual who is the subject of the health information or health information record.

(b) The authorized representative of the individual who is the subject of the health information or health information record.

(c) A third party when written authorization is provided by the individual who is the subject of the health information record or by the authorized representative of the individual who is the subject of the health information or health information record.

(2) Nothing in this Section shall prohibit the disclosure of copies of the complaint filed by the complainant or insured, the response by the person or entity subject to the jurisdiction of the department, or the final disposition to:

(a) The complainant or insured.

(b) The authorized representative of the complainant or insured.

(c) A third party when written authorization is provided by the complainant or insured or by the authorized representative of the complainant or insured.

(3) Nothing in this Section shall prohibit the communication of facts, documents, or other information that is part of a record described in this Section, or the working papers, recorded information, documents, or copies thereof or related thereto, produced by, obtained by, or disclosed to the commissioner, or any other person and in the custody of the commissioner to a state or federal prosecuting attorney, a law enforcement agency, the office of the state inspector general, the state legislative auditor, or the attorney general of this state in connection with their statutory authority, or to any agency or communication district for the purpose of achieving coordinated and effective protection of the public health, safety, or welfare. The department shall also share information with any state or federal agency for the purpose of investigating or determining insurance or tax fraud or the offset of any governmental benefit or with any other government entity authorized by law to conduct any audit, investigation, or similar activity in connection with the administration of any state or federally funded program.

(4) Nothing in this Section shall prohibit the commissioner from using any records or other information in the custody of the department in the furtherance of any

regulatory or legal action brought as part of the commissioner's official duties.

E. The identifiers described in this Section as confidential shall be the following:

(1) Names.

(2) All geographic subdivisions smaller than a state, including street address, city, county or parish, precinct, zip code, and any equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(a) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(b) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(3) All elements of dates, except year, for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and all ages over eighty-nine and all elements of dates, including year, indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety or older.

(4) Telephone numbers.

(5) Facsimile numbers.

(6) Electronic mail addresses.

(7) Social security numbers.

(8) Medical record numbers.

(9) Health plan beneficiary numbers.

(10) Account numbers.

(11) Certificate and license numbers.

(12) Vehicle identifiers and serial numbers, including license plate numbers.

(13) Device identifiers and serial numbers.

(14) Web Universal Resource Locators (URLs).

(15) Internet Protocol (IP) address numbers.

(16) Biometric identifiers, including finger- and voice-prints.

(17) Full face photographic images and any comparable images.

(18) Any other unique identifying number, characteristic, or code.

F. The retention period for records described in this Section shall be no less than three calendar years, and the records may be disposed of thereafter according to R.S. 44:401 et seq.

Added by Acts 2009, No. 367, § 1, eff. July 6, 2009. Amended by Acts 2012, No. 642, § 1, eff. June 7, 2012.

§ 43. Complaints against persons and entities subject to the jurisdiction of the Department of Insurance; file by person or entity subject to jurisdiction; public information

A. The department shall file all complaints which it receives against a person or entity subject to the jurisdiction of the department in a separate file for each such person or entity subject to the jurisdiction of the department. This record shall be maintained in such a manner as to permit the public to readily ascertain information concerning complaints against any person or entity subject to the jurisdiction of the department, without the necessity of reviewing each individual complaint. The retention period for each record described in this Section shall be no less than three calendar years, and any record may be disposed of thereafter according to R.S. 44:401 et seq. The commissioner 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 the following information:

(a) Date of complaint.

(b) Name of the respondent person or entity against whom the complaint is lodged.

(c) Category of the complainant or insured.

(d) Category of the respondent person or entity against whom the complaint is lodged.

(e) Reason for the complaint.

(f) Disposition.

(g) Date of disposition.

(h) The response of the respondent, person or entity against whom the complaint is lodged in addition to the type of coverage.

(i) Type of coverage.

(2) It shall be sufficient for compliance with this Section that the commissioner uses the same coded categorical descriptors established by the National Association of Insurance Commissioners (NAIC) Complaint Database System (CDS) for the commissioner's database fields for the following categorical descriptors:

(a) Category of the complainant or insured.

(b) Category of the respondent person or entity.

(c) Type of coverage.

(d) Reason for complaint.

(e) Disposition.

(3) Where a categorical descriptor for the category of the complainant or insured, category of the respondent person or entity, type of coverage, reason for complaint, or disposition is unique to the state of Louisiana, that unique categorical descriptor shall be reported, and the commissioner shall be in compliance with this Section when using that unique categorical descriptor.

(4) Where the response of the person or entity against whom the complaint is lodged is reported, it shall be sufficient for the commissioner to disclose the following applicable categorical descriptors:

(a) Respondent agreed with complainant.

(b) Respondent disagreed with complainant.

(c) Respondent asserted that insufficient information was provided in the complaint.

(d) No response was provided by respondent.

(e) Respondent did not contest the complaint.

(f) Respondent completed corrective action.

(g) Respondent provided information.

(h) Respondent provided an incomplete response.

(i) Respondent appealed the disposition.

(5) If respondent completes corrective action, the commissioner shall disclose the applicable categorical descriptor for the specific corrective action completed by reporting that categorical descriptor in the categorical descriptor database field for corrective actions.

(6) If an appeal is taken, the final disposition on appeal shall be provided subject to any decision of the appellate tribunal.

(7) The computer program employed by the commissioner shall, at a minimum, be able to sort the information in the database on any of the fields described in this Subsection and print out a written report thereof no later than sixty days from June 7, 2012.

(8) Where there was a final disposition of a complaint prior to June 7, 2012 and the record of that complaint is in the custody of the department, it shall be sufficient for the commissioner to report the information required under this Section utilizing the database described in this Section. It shall not be necessary for those records of complaints to be reviewed for the purpose of applying new categorical descriptors or for new categorical descriptors to be

applied to those complaints.

C. Failure to maintain this record in the manner prescribed herein shall constitute malfeasance on the part of the commissioner of insurance.

Renumbered from R.S. 22:1467 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 622, § 1. Amended by Acts 2009, No. 503, § 1; Acts 2012, No. 642, § 1, eff. June 7, 2012.

§ 44. 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.

Renumbered from R.S. 22:1462.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 464, § 1.

§ 45. 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.

Renumbered from R.S. 22:1468 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 383, § 1, eff. July 6, 1991; Acts 1991, No. 984, § 1, eff. July 24, 1991.

§ 46. General definitions

In this Code, unless the context otherwise requires, the following definitions are 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, that meets the eligibility criteria of R.S. 22:435(A)(2) and (B) and is on the list of

approved unauthorized insurers under the provisions of R.S. 22:436, and from which a licensed surplus lines broker may procure insurance under the provisions of R.S. 22:432.

(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. 22:481 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. "Commissioner" shall mean the commissioner of insurance.

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

(5.1) "Department" shall mean the Department of Insurance.

(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.

(7.1) "Eligible unauthorized insurer" means an insurer without a certificate of authority, or otherwise qualified under the provisions of this Code, that meets the eligibility criteria of R.S. 22:435(A)(2) and (B) and from which a licensed surplus lines broker may procure insurance under the provisions of R.S. 22:432.

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

(8.1)(a) "Home state" means, with respect to an insured on a surplus lines insurance policy, one of the following:

(i) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence.

(ii) If one hundred percent of the insured risk is located out of the state referred to in Item (i) of this Subparagraph, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(iii) If more than one insured from an affiliated group are named insureds on a single surplus lines insurance contract, the state, as determined pursuant to Item (i) or (ii) of this Subparagraph, of the member of the affiliated group that has the largest percentage of premium attributed to it under the surplus lines insurance contract.

(b) The home state as determined in Subparagraph (a) of this Paragraph is the

state that has sole statutory and regulatory jurisdiction over the placement of surplus lines insurance pursuant to 15 U.S.C. 8202 and the exclusive authority to require the payment of any premium tax on surplus lines insurance pursuant to 15 U.S.C. 8201.

(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. The term "insurance" shall not include any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950.

(b)(i) The establishment prior to twelve noon on October 1, 2010, and operation thereafter of at least 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 Subpart E of Part III of Chapter 2 of this Title, R.S. 22:651 et seq., Part IV of Chapter 7 of this Title, R.S. 22:1961 et seq., and Chapters 8 and 12 of this Title, R.S. 22:1981 et seq. and R.S. 22:2191 et seq. An annual audited statement for each such trust shall be filed with the commissioner of insurance by June thirtieth of each year for the immediately preceding year ending December thirty-first or within six months of the close of the fiscal year, only if records are not maintained on a calendar year basis. The commissioner of insurance shall also have the authority to examine the books, records and affairs of the trust funds.

(ii) After twelve noon on October 1, 2010, the establishment and subsequent 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 be deemed to be insurance and such trust or trusts shall be subject to the provisions of this Code.

(c)(i) The establishment prior to twelve noon on October 1, 2010, and operation thereafter of professional and public liability trust funds by a nonprofit beneficiary organization as set forth in Subpart N of Part I of Chapter 2 of this Title, R.S. 22:401 et seq., 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 Subpart E of Part III of Chapter 2 of this Title, Part IV of Chapter 7 of this Title, and Chapters 8 and 12 of this Title. An annual audited statement shall be filed with the commissioner of insurance by June thirtieth of each year for the immediately preceding year ending December thirty-first or within six months of the close of the fiscal year, only if records are not maintained on a calendar year basis. The commissioner of insurance shall also have the authority to examine the books, records, and affairs of the trust fund.

(ii) After twelve noon on October 1, 2010, the establishment and subsequent operation of professional and public liability trust funds by a nonprofit beneficiary organization for the purpose of indemnifying nonprofit beneficiary organizations and their officers, directors, and agents for financial loss due to the imposition of legal liability claims or judgments arising from such claims shall be deemed to be insurance and such trust or trusts shall be subject to the provisions of this Code.

(d)(i) The establishment prior to twelve noon on October 1, 2010, and operation thereafter of at least 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 Subpart E of Part III of Chapter 2 of this Title, Part IV of Chapter 7 of this Title, and Chapters 8 and 12 of this Title. An annual audited statement shall be filed with the commissioner of insurance by June thirtieth of each year for the immediately preceding year ending December thirty-first or within six months of the close of the fiscal year, only if records are not maintained on a calendar year basis. The commissioner of insurance shall also have the authority to examine the books, records, and affairs of the trust fund.

(ii) After twelve noon on October 1, 2010, the establishment and subsequent 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 be deemed to be insurance and such trust or trusts shall be subject to the provisions of this Code.

(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 Subparagraph (9)(a) of this Section is an insurer. A health maintenance organization is an insurer but only for the purposes enumerated in R.S. 22:242(7). The term "insurer" shall not include any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, nor shall such arrangement or trust be deemed an insurer.

(11) "Life insurer" shall mean all insurers issuing life insurance contracts, including industrial and service insurers.

(11.1) "Officer" shall mean 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.

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

(13) "Premium" 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. 22:885(B) and 887(D), 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.

(13.1) "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 this Code as "insurance agent", "agent", "insurance broker", "broker", "insurance solicitor", "solicitor", or "surplus lines broker".

(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" 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 property, risk, or exposure located or to be performed in this state, permitted to be placed through a licensed surplus lines broker with a surplus lines insurer.

(17.1) "Surplus lines insurer" means an approved unauthorized insurer or eligible unauthorized insurer, as defined in this Section, or a domestic surplus lines insurer as provided in R.S. 22:436.1.

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

Renumbered from R.S. 22:5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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, eff. July 12, 1999; Acts 1999, No. 1312, § 1, eff. July 12, 1999; Acts 2002, 1st Ex.Sess., No. 87, § 1; Acts 2003, No. 70, § 1; Acts 2004, No. 325, § 1, eff. June 18, 2004; Acts 2009, No. 503, § 1; Acts 2010, No. 338, § 1; Acts 2010, No. 415, § 1, eff. June 21, 2010; Acts 2010, No. 794, § 1; Acts 2013, No. 203, § 1, eff. June 10, 2013; Acts 2015, No. 193, § 1.

§ 47. 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 additional benefits, including the acceleration of life 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) Health and accident.

(a) 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, 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 Subpart I of Part I of Chapter 2 of this Title, R.S. 22:241 et seq., for provision of coverage through designated providers of medical services.

(b) Health stop loss. Insurance 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.

(c) 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.

(3) Vehicle.

(a) Insurance against loss or damage to any land vehicle 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 animal.

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

(4) Liability.

(a) 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.

(b) Insurance coverage that provides indemnity, on behalf of an insured, for any

legal responsibility from the damage to or the destruction of another person's property or the infliction of injury on another person that is caused by an insured's negligence, carelessness, or failure to act.

(5) Workers' compensation. Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for workers' compensation, which may include employers' liability. Any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, is not insurance nor shall such arrangement or trust be deemed to be insurance.

(6) Burglary and forgery. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, or otherwise, including the personal property floater; also coverage of expenses associated with kidnapping or ransom demands.

(7) Repealed by Acts 2009, No. 326, § 2, eff. Jan. 1, 2010.

(8) Fidelity. A contract whereby one becomes a guarantor for any person in any position or place of trust or as custodian of money or property, public or private.

(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 allied lines.

(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 or 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.

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

(g) Insurance against loss by death or damage to livestock from disease, lightning, tornadoes, cyclones, accidents, and every other casual or accidental cause; also against theft.

(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. Insurance against loss or damage from insects, hail, diseases, or other causes to trees, crops, or other products of the soil.

(13) Marine and transportation.

(a) Insurance against loss or damage to vessels, craft, aircraft, or 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, live animals, 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, transshipment, 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 provides coverage for any legal liability assumed by an 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.

(f) Veterinary care plan insurance providing care for a pet animal of an insured owner in the event of illness, accident, or death.

(g) Insurance against financial loss due to trip cancellation or interruption, lost or damaged baggage, trip or baggage delay, missed connections, or changes in itinerary.

(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 partially or wholly extinguish the credit obligation, including but not limited to agreements, contracts, or policies of insurance containing the following: credit life, credit health, and disability. The amount of credit insurance issued pursuant to a credit transaction shall not exceed the total sum payable under the contract, including all loan finance and credit service charges. 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.

(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.

(18) Surety. A contract whereby one becomes a surety or guarantor for the performance of any person 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 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.

(19) Industrial fire. Fire and allied lines insurance policies issued through producers operating on the debit agency system, under which system a weekly or monthly collection percentage is paid based either on actual weekly or monthly premium collections or weekly or monthly increases of premium collections and where the face amount of the insurance provided covering buildings and other structures or contents under the same ownership shall not exceed forty thousand dollars for the structure and forty thousand dollars for contents.

Renumbered from R.S. 22:6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1969, No. 73, § 1; Acts 1983, No. 351, § 2; Acts 1991, No. 909, § 1; Acts 1995, No. 593, § 1; Acts 1999, No. 1312, § 1, eff., July 12, 1999; 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; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2009, No. 503, § 1; Acts 2010, No. 794, § 1.

§ 48. Types of insurers and other risk bearing entities

A. The following entities are regulated by specific provisions in the Louisiana Insurance Code:

(1) Domestic stock insurers.

(2) Domestic mutual insurers.

(3) Domestic service insurers.

(4) Industrial insurers.

(5) Reciprocal insurers.

(6) Nonprofit funeral service associations.

(7) Mutual insurance holding companies.

(8) Health maintenance organizations.

(9) Fraternal benefit societies.

(10) Foreign and alien insurers.

(11) Vehicle mechanical breakdown insurers.

(12) Property residual value insurers.

(13) Nonprofit beneficiary organizations and risk indemnification trusts.

(14) Surplus line insurers.

(15) Group self insurers, provided that any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall not be regulated under the Louisiana Insurance Code.

(16) Risk retention groups.

(17) Title insurers.

B. The provisions of this Section shall not preclude the Department of Insurance from regulating any other entity that meets the definition of an insurer or risk bearing entity as defined in this Title unless specifically excluded from regulation by the department.

Added by Acts 2008, No. 410, § 1, eff. Jan. 1, 2009. Amended by Acts 2009, No. 503, § 1; Acts 2010, No. 794, § 1.

Effective Date—Acts 2008, No. 410

Section 2 of Acts 2008, No. 410 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall take effect and become operative if and when the Act which originated as Senate Bill No. 335 of this 2008 Regular Session of the Legislature is enacted and becomes law and is effective."

Senate Bill No. 335 of the 2008 Regular Session was enacted as Act 415, signed by the governor on June 21, 2008, and became effective on January 1, 2009.

§ 49. Repealed by Acts 2009, No. 503, § 2

§ 50. Reimbursement to a unique provider of health services

Health insurance issuers shall provide coverage and reimbursement to a unique provider of health services for catastrophically ill children, as defined by R.S. 40:1077.1(2), located outside the state of Louisiana in accordance with the terms and conditions of the policy of insurance between the insured and the insurer.

Added by Acts 2009, No. 419, § 1.

CHAPTER 2. REQUIREMENTS FOR INSURERS AND OTHER RISK BEARING ENTITIES

PART I. KINDS OF INSURERS

SUBPART A. DOMESTIC INSURERS—GENERALLY

§ 61. 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.

Renumbered from R.S. 22:31 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 62. 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 and municipal addresses or locations, which shall not be a post office box only, 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, and 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, if any.

(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.

Renumbered from R.S. 22:32 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2006, No. 340, § 1, eff. June 13, 2006; Acts 2009, No. 503, § 1.

§ 63. 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 this Title.

Renumbered from R.S. 22:33 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 152, § 1; Acts 2009, No. 503, § 1.

§ 64. 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. Repealed by Acts 2009, No. 503, § 2.

Renumbered from R.S. 22:34 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 391, § 1; Acts 1999, No. 342, § 6.

§ 65. 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) Repealed by Acts 2009, No. 503, § 2.

(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) Repealed by Acts 2009, No. 503, § 2.

(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 provisions of this Paragraph pursuant to the Administrative Procedure Act.[1]

Renumbered from R.S. 22:35 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1989, No. 604, § 1, eff. Sept. 1, 1989; Acts 1991, No. 771, § 1; Acts 1992, No. 704, § 1; Acts 2009, No. 503, § 1.

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

§ 66. 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.

Renumbered from R.S. 22:37 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 67. 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, R.S. 12:31 et seq.

Renumbered from R.S. 22:38 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1983, No. 305, § 1; Acts 2009, No. 503, § 1.

§ 68. 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. 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 five 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. 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. The commissioner of insurance is hereby authorized to promulgate rules and regulations pursuant to this Subsection.

D. 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.

Renumbered from R.S. 22:39 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1979, No. 115, § 1. Amended by Acts 2001, No. 302, § 1; Acts 2004, No. 342, § 1; Acts 2009, No. 503, § 1; Acts 2010, No. 7, § 3, eff. May 19, 2010; Acts 2010, No. 212, § 1.

§ 69. Business Corporation Act governs when Insurance Code silent

The provisions of the Louisiana Business Corporation Act, as provided in R.S. 12:1-101 through R.S. 12:1-1704, 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 this Subpart and Subpart B of this Part, in those situations in which the provisions of this Title are silent. If a conflict exists between the provisions of this Title and said provisions of Title 12, the provisions of the Louisiana Insurance Code [1] shall govern.

Renumbered from R.S. 22:40 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 715, § 1. Amended by Acts 2009, No. 503, § 1.

[1] R.S. 22:1 et seq.

§ 70. 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.

Renumbered from R.S. 22:1461 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1976, No. 454, § 1.

§ 71. Conversion requirements

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.

Renumbered from R.S. 22:801 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 167, § 1; Acts 1975, No. 575, § 1; Acts 2009, No. 503, § 1.

§ 72. Stock and mutual conversions

A. 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. 22:71 unless a plan of conversion is submitted to and approved by the commissioner of insurance.

B. The commissioner of insurance shall not approve any such conversion unless in his opinion after a full investigation the best interests of the policyholders of any such insurer will be served.

C. The conversion of a mutual life insurer or a mutual life insurance holding company shall also comply with Subpart H-1 of this Part, R.S. 22:236 et seq. "Mutual life insurer" and "mutual life insurance holding company" shall have the meanings set forth in R.S. 22:236.

Renumbered from R.S. 22:806 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2008, No. 307, § 1, eff. June 17, 2008; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 73. 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 of insurance 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. 22:2025. 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 in this Section.

Renumbered from R.S. 22:741 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1989, No. 446, § 1, eff. Sept. 1, 1989; Acts 1993, No. 955, § 1; Acts 2009, No. 503, § 1.

§ 74. 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. A domestic insurer shall also not discount commercial or other than first mortgage paper nor engage in any banking business whatsoever.

Added by Acts 2009, No. 503, § 1.

§ 75. 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.

Redesignated from R.S. 22:1486 by Acts 2010, No. 703, § 3, eff. Jan. 1, 2011. R.S. 22:1486 renumbered from R.S. 22:1461.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 165, § 1, eff. June 29, 1988. Amended by Acts 1993, No. 663, § 2, eff. June 16, 1993.

SUBPART B. DOMESTIC STOCK INSURERS

§ 81. 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:

<COL>Insurance<COL>Paid-in Capital<COL>Minimum Surplus

(1)<COL>Life<COL>$ 100,000<COL>$ 200,000

(2)<COL>Health and accident<COL>100,000<COL>200,000

<COL>(1) and (2) above<COL>100,000<COL>200,000

(3)<COL>Vehicle<COL>650,000<COL>350,000

(4)<COL>Liability<COL>650,000<COL>350,000

(5)<COL>Workers' compensation<COL><COL>

<COL>(a)<COL>Any company organized and authorized to transact workers' compensation only on or before July 27, 1966<COL>100,000<COL>50,000

<COL>(b)<COL>Any company organized and authorized to transact workers' compensation only after July 27, 1966<COL>650,000<COL>350,000

(6)<COL>Burglary and forgery<COL>650,000<COL>350,000

(7)<COL>Fidelity<COL>650,000<COL>350,000

(8)<COL>Title<COL><COL>

<COL>(a)<COL>Any company licensed to transact title insurance prior to September 1, 1985<COL>50,000<COL>25,000

<COL>(b)<COL>Any company licensed to transact title insurance on or after September 1, 1985<COL>100,000<COL>200,000

(9)<COL>Fire and allied lines<COL>650,000<COL>350,000

(10)<COL>Steam boiler and sprinkler leakage<COL>650,000<COL>350,000

(11)<COL>Crop<COL><COL>

<COL>(a)<COL>Any company organized and authorized to transact crop insurance only on or before July 27, 1966<COL>100,000<COL>150,000

<COL>(b)<COL>Any company organized and authorized to transact crop insurance only after July 27, 1966<COL>650,000<COL>350,000

(12)<COL>Marine and transportation<COL>650,000<COL>350,000

(13)<COL>Miscellaneous<COL>650,000<COL>350,000

(14)<COL>Homeowners' insurance<COL>650,000<COL>350,000

(15)<COL>Credit life, health, and accident insurance<COL>100,000<COL>200,000

(16)<COL>Credit property and casualty insurance<COL>650,000<COL>350,000

(17)<COL>Annuity<COL>100,000<COL>200,000

(18)<COL>Surety<COL>650,000<COL>350,000

(19)<COL>Industrial fire<COL>200,000<COL>100,000

(20)<COL>All insurances, except life and title or<COL>650,000<COL>350,000

<COL>combined capital and surplus<COL>1,000,000<COL>

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:

(a) Health and accident insurance.

(b) Annuity.

(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.

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. 22:82.

Renumbered from R.S. 22:71 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 101, § 1. Amended by 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 1985, No. 718, § 1, eff. Sept. 1, 1985; Acts 1989, No. 562, § 1; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2009, No. 503, § 1.

§ 82. 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:

<COL>Insurance<COL>Paid-in Capital<COL>Minimum Surplus<COL>Operating Surplus

(1)<COL>Life<COL>$100,000<COL>$1,900,000<COL>$1,000,000

(2)<COL>Health and accident<COL>100,000<COL>1,900,000<COL>1,000,000

<COL>(1) and (2) above<COL>100,000<COL>1,900,000<COL>1,000,000

(3)<COL>Vehicle<COL>650,000<COL>1,350,000<COL>1,000,000

(4)<COL>Liability<COL>650,000<COL>1,350,000<COL>1,000,000

(5)<COL>Workers' compensation<COL>650,000<COL>1,350,000<COL>1,000,000

(6)<COL>Burglary and forgery<COL>650,000<COL>1,350,000<COL>1,000,000

(7)<COL>Fidelity<COL>650,000<COL>1,350,000<COL>1,000,000

(8)<COL>Title<COL>100,000<COL>400,000<COL>500,000

(9)<COL>Fire and allied lines<COL>650,000<COL>1,350,000<COL>1,000,000

(10)<COL>Steam boiler and sprinkler leakage<COL>650,000<COL>1,350,000<COL>1,000,000

(11)<COL>Crop<COL>650,000<COL>1,350,000<COL>1,000,000

(12)<COL>Marine and transportation<COL>650,000<COL>1,350,000<COL>1,000,000

(13)<COL>Miscellaneous<COL>650,000<COL>1,350,000<COL>1,000,000

(14)<COL>Homeowners' insurance<COL>650,000<COL>1,350,000<COL>1,000,000

(15)<COL>Credit life, health, and accident insurance<COL>100,000<COL>1,900,000<COL>1,000,000

(16)<COL>Credit property and casualty insurance<COL>650,000<COL>1,350,000<COL>1,000,000

(17)<COL>Annuity<COL>100,000<COL>1,900,000<COL>1,000,000

(18)<COL>Surety<COL>650,000<COL>1,350,000<COL>1,000,000

(19)<COL>Industrial fire<COL>200,000<COL>800,000<COL>1,000,000

(20)<COL>All insurances except life and title<COL>650,000<COL>1,350,000<COL>1,000,000

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:

(a) Health and accident insurance.

(b) Annuity.

(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.

C. For the purposes 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.

Renumbered from R.S. 22:71.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 562, § 1. Amended by Acts 2003, No. 131, § 1; Acts 2005, No. 27, § 1, eff. June 9, 2005; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2009, No. 503, § 1.

§ 83. 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. 22:81 or 82, 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.

Renumbered from R.S. 22:71.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

§ 84. 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. 22:81. 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.

Renumbered from R.S. 22:72 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1982, No. 341, § 1.

§ 85. 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. 22:67.

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. 22:584, except in the case of stock dividends, and new stock certificates issued.

Renumbered from R.S. 22:73 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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.

§ 86. 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 percent 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.

Renumbered from R.S. 22:74 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 87. Stock dividends

Stock dividends may be declared and paid in the manner specified in R.S. 22:85 except that publication of the notice and the payment in cash shall not be required.

Renumbered from R.S. 22:75 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 88. Sales of stock

A. (1) All sales of stock as defined in this Section shall be made in accordance with the regulations contained in this Section.

(2) When used in this Section, the following terms shall have the following respective meanings:

(a)(i) "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.

(ii) For the purposes 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.

(b) "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.

(c) "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.

(d) "Dealer" shall include every person, or investment counsel or investment counselor, 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; however, 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.

(e) "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.

(f) "Salesman" shall include every natural person, including producers, 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.

(g) "Broker" shall mean dealer as defined in this Subsection.

(h) "Agent" shall mean salesman as defined in this Subsection.

(i) "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 Paragraph (1).

(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. (1) 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:

(a) 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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.

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

(i) 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

(ii) 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

(iii) Either Moody's, Standard and Poor's, or Fetch 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 eighteen 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.

(2) 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. (1) 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 defined in Subsection A of this Section 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.

(2) 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.

(3) 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. (1) 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:

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

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

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

(d) 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 percent.

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

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

(2) 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.

(3) The filing of such statement and documents in the office of the commissioner, and the payment of the fee provided for in this Subsection 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 provided in this Subsection. 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. 22:85. 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 thirty-first 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 provided in this Subsection.

(4) 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 specified in Subsection F of this Section 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.

(5) In the event of the entry of such order of rejection or suspension, the aggrieved party may demand a prompt hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq. If no hearing is timely requested the commissioner 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. If, however, upon a hearing the division of administrative law shall find that the security being offered for sale will neither be fraudulent nor result in fraud, the commissioner 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.

(6) At the time of filing the statement and documents enumerated in this Subsection and upon re-registration, the applicant shall pay to the commissioner a fee of one-twentieth of one percent 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 or more than two hundred dollars. 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.

(1) 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:

(a) Is insolvent.

(b) 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.

(c) Has been or is engaged or is about to engage in a fraudulent transaction.

(d) 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.

(e) Is of bad business repute.

(f) Does not conduct its business in accordance with law.

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

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

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(1) 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.

(2) 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.

(3) 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 of this Section.

(4) 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 provided for in this Subsection, he shall register such applicant as a dealer.

(5) 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.

(6) 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 thirty-first of each year, but new registrations for the succeeding year shall be issued upon written application and upon payment of the fee as provided for in this Subsection 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.

(7) 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.

(8) 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.

(9) 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.

(1) Registration under Subsection H of this Section 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 has committed any of the following acts:

(a) Has violated any provision of this Section or any regulation made hereunder pursuant to this Section.

(b) Has made a material false statement in the application for registration.

(c) 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.

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

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

(3) The aggrieved party whose registration is refused or revoked may demand a

hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq. Notwithstanding any law to the contrary, if a hearing is timely requested by the aggrieved party, the commissioner's order or act shall be stayed until the decision of the division of administrative law is issued. The commissioner may seek an expedited hearing before the division of administrative law to suspend the registration, pending the outcome of the main hearing.

(4) Until the entry of a final order by the division of administrative law, any 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.

(5) In the event the commissioner determines to refuse or to revoke a registration as provided in this Subsection, 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.

(6) 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 percent, 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.

(1) 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 has committed any of the following acts, the commissioner may investigate and, upon evidence satisfactory to him, 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:

(a) Has 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.

(b) Has made, makes, or attempts to make in this state fictitious or pretended purchases or sales of securities as defined in this Section.

(c) Has 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:

(i) 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.

(ii) Which is fraudulent.

(iii) 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 referred to in this Section as fraudulent practices.

(d) Is acting as a dealer or salesman within this state without being duly registered as such dealer or salesman as provided in this Section.

(2) 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; the production of documents, books, and records as may appear necessary for the hearing of such petition; and testimony and 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 solid 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 percent per annum, less, in any case, the amount of any income from said insurance securities that may have been received by such purchaser.

M. Violations; penalties.

(1)(a) 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.

(b) Whoever violates this Paragraph 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)(a) 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.

(b) Whoever violates this Paragraph 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)(a) 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 Subsection E of this Section, 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.

(b) Whoever violates this Paragraph 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)(a) 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 wilful signing of such statement or document.

(b) Whoever violates this Paragraph 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 from the division of administrative law may be taken by the aggrieved person in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

P. Fees.

(1) 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.

(2) 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 one half 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.

Renumbered from R.S. 22:76 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 83, §§ 1, 3. Amended by Acts 1960, No. 164, §§ 1 to 3; Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 89. 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 R.S. 22:73, 96, and Chapter 9 of this Title and Subpart H of Part III of this Chapter.

Renumbered from R.S. 22:77 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 90. 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. 22:81, 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.

Renumbered from R.S. 22:78 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 91. 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.

Renumbered from R.S. 22:79 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 92. 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.

Renumbered from R.S. 22:80 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1968, No. 489, § 1; Acts 1988, No. 159, § 1.

§ 93. 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.

Renumbered from R.S. 22:81 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1962, No. 306, § 1; Acts 1978, No. 765, § 1; Acts 1982, No. 248, § 1.

§ 94. Duties of officers

A. 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.

B. 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.

Renumbered from R.S. 22:82 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1974, No. 4, § 1; Acts 2009, No. 503, § 1.

§ 95. 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. 22:134

and 22:148.

Renumbered from R.S. 22:84 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 96. 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 Subpart E of Part III of this Chapter R.S. 22:651, et seq.; 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 Subpart E of Part III of this Chapter. 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.

Renumbered from R.S. 22:764 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

SUBPART C. DOMESTIC MUTUAL INSURERS

§ 111. 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:

<COL><COL>Insurance<COL>Initial Minimum Surplus

<COL>(1)<COL>Life<COL>$ 300,000

<COL>(2)<COL>Health and accident<COL>300,000

<COL><COL>(1) and (2) above<COL>300,000

<COL>(3)<COL>Vehicle<COL>1,000,000

<COL>(4)<COL>Liability<COL>1,000,000

<COL>(5)<COL>Workers' compensation<COL>

<COL><COL>(a)<COL>Any company organized and authorized to transact workers' compensation only on or before July 27, 1966<COL>150,000

<COL><COL>(b)<COL>Any company organized and authorized to transact workers' compensation only after July 27, 1966<COL>1,000,000

<COL>(6)<COL>Burglary and forgery<COL>1,000,000

<COL>(7)<COL>Fidelity<COL>1,000,000

<COL>(8)<COL>Title<COL>75,000

<COL>(9)<COL>Fire and allied lines<COL>1,000,000

<COL>(10)<COL>Steam boiler and sprinkler leakage<COL>1,000,000

<COL>(11)<COL>Crop<COL>

<COL><COL>(a)<COL>Any company organized and authorized to transact crop insurance only on or before July 27, 1966<COL>250,000

<COL><COL>(b)<COL>Any company organized and authorized to transact crop insurance only after July 27, 1966<COL>1,000,000

<COL>(12)<COL>Marine and transportation (except hull)<COL>1,000,000

<COL>(13)<COL>Miscellaneous<COL>1,000,000

<COL>(14)<COL>Homeowners' insurance<COL>1,000,000

<COL>(15)<COL>Credit life, health, and accident insurance<COL>300,000

<COL>(16)<COL>Credit property and casualty insurance<COL>1,000,000

<COL>(17)<COL>Annuity<COL>300,000

<COL>(18)<COL>Surety<COL>1,000,000

<COL>(19)<COL>Industrial fire<COL>300,000

<COL>(20)<COL>All insurances, except life and title<COL>1,000,000

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:

(a) Health and accident insurance.

(b) Annuity.

(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.

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. 22:112.

Renumbered from R.S. 22:121 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 103, § 1. Amended by 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 1985, No. 504, § 1; Acts 1989, No. 561, § 1; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2009, No. 503, § 1.

§ 112. 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:

<COL>Insurance<COL>Initial Minimum Surplus<COL>Operating Surplus

(1)<COL>Life<COL>$2,000,000<COL>$1,000,000

(2)<COL>Health and accident<COL>2,000,000<COL>1,000,000

<COL>(1) and (2) above<COL>2,000,000<COL>1,000,000

(3)<COL>Vehicle<COL>2,000,000<COL>1,000,000

(4)<COL>Liability<COL>2,000,000<COL>1,000,000

(5)<COL>Workers' compensation<COL>2,000,000<COL>1,000,000

(6)<COL>Burglary and forgery<COL>2,000,000<COL>1,000,000

(7)<COL>Fidelity<COL>2,000,000<COL>1,000,000

(8)<COL>Title<COL>500,000<COL>500,000

(9)<COL>Fire and allied lines<COL>2,000,000<COL>1,000,000

(10)<COL>Steam boiler and sprinkler leakage<COL>2,000,000<COL>1,000,000

(11)<COL>Crop<COL>2,000,000<COL>1,000,000

(12)<COL>Marine and transportation (except hull)<COL>2,000,000<COL>1,000,000

(13)<COL>Miscellaneous<COL>2,000,000<COL>1,000,000

(14)<COL>Homeowners' insurance<COL>2,000,000<COL>1,000,000

(15)<COL>Credit life, health, and accident insurance<COL>2,000,000<COL>1,000,000

(16)<COL>Credit property and casualty insurance<COL>2,000,000<COL>1,000,000

(17)<COL>Annuity<COL>2,000,000<COL>1,000,000

(18)<COL>Surety<COL>2,000,000<COL>1,000,000

(19)<COL>Industrial fire<COL>1,000,000<COL>1,000,000

(20)<COL>All insurances, except life and title<COL>2,000,000<COL>1,000,000

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:

(a) Health and accident insurance.

(b) Annuity.

(c) Credit life, health, and accident insurance.

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

C. For the purposes 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.

Renumbered from R.S. 22:121.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 561, § 1. Amended by Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2009, No. 503, § 1.

§ 113. Additional surplus

The commissioner may require a domestic mutual insurer to have and maintain a greater amount of surplus than prescribed in R.S. 22:111 or 112, 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.

Renumbered from R.S. 22:121.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

§ 114. 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. 22:111(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.

Renumbered from R.S. 22:122 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1985, No. 504, § 1.

§ 115. 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.

Renumbered from R.S. 22:123 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 116. Methods of acquiring surplus

The initial minimum sum required may be raised by the insurer in either of the following manners:

(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. 22:115, 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 .

(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. 22:111 upon an agreement with the lender that the same, with interest at a rate not exceeding eight 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 and to maintain a full reserve against all its policies and to maintain the minimum surplus required by R.S. 22:111. 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 requirements of this Section.

Renumbered from R.S. 22:124 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1962, No. 48, § 1; Acts 2009, No. 503, § 1.

§ 117. 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. 22:116(2), equal to fifteen percent of such initial minimum surplus.

Renumbered from R.S. 22:125 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 118. 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. 22:116(2), provided the transaction is submitted to and approved by the commissioner of insurance.

Renumbered from R.S. 22:126 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 119. Policyholders' meetings; voting rights

A. 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.

B. 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.

Renumbered from R.S. 22:127 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 120. 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. 22:119;

(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

thirty-first report of the insurer;

(6) The board of directors shall meet at least six times a year and as 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 charter or bylaws may provide. However, the directors of a risk retention insurer to which the laws of this Subpart apply shall annually elect from the nonpolicy holder directors a president, a secretary, and such other officers as the charter or bylaws may provide.

Renumbered from R.S. 22:128 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1964, No. 134, § 1; Acts 1989, No. 689, § 1; Acts 2009, No. 503, § 1.

§ 121. 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.

Renumbered from R.S. 22:129 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1974, No. 4, § 1.

§ 122. Non-assessable policies; authority to issue

Except as provided in R.S. 22:114, any domestic mutual insurer not organized under the legal reserve plan for the writing of life insurance, as defined under R.S. 22:47(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.

Renumbered from R.S. 22:131 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 123. 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.

Renumbered from R.S. 22:132 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 124. 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 this Title. 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.

Renumbered from R.S. 22:133 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1994, 3rd Ex.Sess., No. 92, § 1. Amended by Acts 2009, No. 503, § 1.

SUBPART D. DOMESTIC SERVICE INSURERS

§ 131. 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.

Renumbered from R.S. 22:291 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 132. Policy provisions

A. No service insurer shall issue a policy for a term of more than twenty 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.

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. 22:149(A)(2), (4), (5), (6), (7), (8), and (9).

Renumbered from R.S. 22:292 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1.

§ 133. Deposits

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. Such 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.

Renumbered from R.S. 22:293 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 166, § 1; Acts 1981, No. 856, § 1; Acts 1982, No. 748, § 1; Acts 2009, No. 503, § 1.

§ 134. Capital requirements

All domestic insurers qualifying to write service insurance only shall in lieu of the capital requirements of R.S. 22:81 or the minimum surplus requirements of R.S. 22:111 and 22:114, 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.

Renumbered from R.S. 22:294 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 1960, No. 174, § 1.

§ 135. Incorporation of service insurers prohibited

No domestic service insurance company may be organized and no alien or foreign service insurer may be qualified by this Subpart to do business in this state after twelve o'clock noon of August 1, 1964.

Renumbered from R.S. 22:295 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1964, No. 151, § 1. Amended by Acts 2009, No. 503, § 1.

SUBPART E. INDUSTRIAL INSURERS

§ 141. Industrial insurance defined

Industrial life insurance is hereby defined and shall be construed to be that insurance which is issued by: (1) a 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. 22:142, 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. 22:146 and 149, respectively.

Renumbered from R.S. 22:251 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1958, No. 94, § 2, eff. Jan. 1, 1959 at 12:00 Noon; Acts 2009, No. 503, § 1.

§ 142. 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. 22:81 or 111 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 forty dollars per week.

(3) A policy providing benefits for dismembered and broken limbs, and/or loss of eyesight in the aggregate of one thousand dollars 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 one thousand dollars per policy year.

(5) A policy providing accidental death benefits of one thousand dollars.

B. Repealed by Acts 1997, No. 184, § 2.

C. The limits provided in Subsection A of this Section shall be increased to the underwriting limits provided in R.S. 22:148 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.

Renumbered from R.S. 22:252 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1958, No. 95, § 1, eff. Jan. 1, 1959 at 12:00 Noon; Acts 1960, No. 143, § 1; Acts 1974, No. 4, § 2; Acts 1997, No. 184, § 1; Acts 2009, No. 503, § 1.

§ 143. 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 this Subpart 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 July 6, 2004, and all claims arising or actions filed on or after July 6, 2004. The provisions of this Paragraph shall not be construed to affect 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. 22:751. 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. 22:131(1), 142, 143, 192, and 197 shall be sold after 12:00 midnight July 31, 1997.

Renumbered from R.S. 22:253 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1.

§ 144. 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. 22:81, or the minimum surplus requirements of R.S. 22:111 and 22:114, 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.

Renumbered from R.S. 22:254 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 150, § 1.

§ 145. 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.

Renumbered from R.S. 22:255 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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.

§ 146. 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. 22:751 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 provided in this Section. 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 provided in this Section. 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.

Renumbered from R.S. 22:256 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 93, § 1. Amended by Acts 1974, No. 4, § 2; Acts 2009, No. 503, § 1.

§ 147. Policies under standard non-forfeiture law excepted

The provisions of R.S. 22:146 shall not apply to any policy issued by any industrial insurer under the provisions of R.S. 22:936.

Renumbered from R.S. 22:257 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 148. 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 Subpart applicable to industrial insurers except as to amount.

Renumbered from R.S. 22:258 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1974, No. 4, § 2; Acts 2009, No. 503, § 1.

§ 149. Required policy provisions

A. 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) Grace period. 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) The contract. 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) Incontestability. 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 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 Subsection, whether or not such provision is excepted in such clause.

(4) Misstatement of age. 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) Participating policy. 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) Reinstatement. 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) Claim provision. 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) Subject of insurance. A title on the face of the policy briefly describing its form.

(9) Beneficiary requirement. 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.

B. Exclusions and limitations. 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:

(1) 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.

(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.

(2) In the event of death as to which there is an exclusion or restriction pursuant to Subparagraph (1)(a), (c), (d), or (e) of this Subsection, 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.

(3) In the event of death as to which there is an exclusion or restriction pursuant to Subparagraph (1)(b) of this Subsection, the insurer shall pay the greater of: (a) the amount specified in Paragraph (2) of this Subsection; 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.

(4) None of the provisions of this Subsection shall apply to policies issued under R.S. 22:143 and 751(E), nor to any accidental benefits in the event such death be by accident or accidental means included in a life policy.

Renumbered from R.S. 22:259 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 96, § 1. Amended by Acts 1960, No. 168, § 1; Acts 2009, No. 503, § 1.

§ 150. Exceptions

The requirements in R.S. 22:149 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 provisions of R.S. 22:149 shall apply only to the life insurance portion of the policy.

(2) Any of the provisions of R.S. 22:149 or portions thereof not applicable to non-participating or term or paid-up policies shall to that extent not be incorporated therein.

Renumbered from R.S. 22:260 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

SUBPART F. RECIPROCAL INSURERS

§ 161. Scope of Subpart

A. This Subpart shall apply to all reciprocal insurers organized or authorized to transact business in this state.

B. As used in this Subpart, "subscriber" means the participant or policyholder; "attorney-in-fact" means the representative of the subscribers through whom reciprocal insurance is exchanged; and "reciprocal insurer" means the organization or group of all the subscribers.

Renumbered from R.S. 22:431 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 162. 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.

Renumbered from R.S. 22:432 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 163. 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.

Renumbered from R.S. 22:433 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 164. 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.

Renumbered from R.S. 22:434 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 165. 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:

<COL>Insurance<COL>Initial Minimum Surplus<COL>

(1)<COL>Health and accident<COL>$ 300,000<COL>

(2)<COL>Vehicle<COL>1,000,000<COL>

(3)<COL>Liability<COL>1,000,000<COL>

(4)<COL>Workers' compensation<COL><COL>

<COL>(a)<COL>Any company organized and authorized to transact workers' compensation only on or before July 27, 1966<COL>150,000<COL>

<COL>(b)<COL>Any company organized and authorized to transact workers' compensation only after July 27, 1966<COL>1,000,000<COL>

(5)<COL>Burglary and forgery<COL>1,000,000<COL>

(6)<COL>Fidelity<COL>1,000,000<COL>

(7)<COL>Title<COL>75,000<COL>

(8)<COL>Fire and allied lines<COL>1,000,000<COL>

(9)<COL>Steam boiler and sprinkler damage<COL>1,000,000<COL>

(10)<COL>Crop<COL><COL>

<COL>(a)<COL>Any company organized and authorized to transact crop insurance only on or before July 27, 1966<COL>250,000<COL>

<COL>(b)<COL>Any company organized and authorized to transact crop insurance only after July 27, 1966<COL>1,000,000<COL>

(11)<COL>Marine and transportation<COL>1,000,000<COL>

(12)<COL>Miscellaneous<COL>1,000,000<COL>

(13)<COL>Homeowners' insurance<COL>1,000,000<COL>

(14)<COL>Credit health and accident insurance<COL>300,000<COL>

(15)<COL>Credit property and casualty insurance<COL>1,000,000<COL>

(16)<COL>Surety<COL>1,000,000<COL>

(17)<COL>Industrial fire<COL>300,000<COL>

(18)<COL>All insurances, except life and title<COL>1,000,000<COL>

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 on or before August 1, 1967.

Renumbered from R.S. 22:435 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 102, § 1. Amended by Acts 1962, No. 50, § 1; Acts 1966, No. 72, § 1; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2009, No. 503, § 1.

§ 166. 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.

Renumbered from R.S. 22:437 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 167. Declaration of organization

The attorney-in-fact of subscribers who desire to form a reciprocal insurer under this Subpart 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.

Renumbered from R.S. 22:438 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 168. Documents to be filed

A. 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.

B. Upon approval of the commissioner of insurance, he shall record with the secretary of state a copy of 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.

Renumbered from R.S. 22:439 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 169. Repealed by Acts 2009, No. 503, § 2

§ 170. 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.

Renumbered from R.S. 22:441 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 171. 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 II of Chapter 3 of this Title.

Renumbered from R.S. 22:442 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1981, No. 856, § 1; Acts 2009, No. 503, § 1.

§ 172. 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. 22:165, 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.

Renumbered from R.S. 22:443 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 173. 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.

Renumbered from R.S. 22:444 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 174. Subscribers' liability

A. Except as to non-assessable policies, any contract of insurance exchanged pursuant to this Subpart 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.

Renumbered from R.S. 22:445 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 175. Non-assessable contracts

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.

Renumbered from R.S. 22:446 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 176. 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 percent 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. 22:165. 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.

Renumbered from R.S. 22:447 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 177. 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 or certified mail, or by commercial courier as defined in R.S. 13:3204(D), giving the day and hour of such service.

Renumbered from R.S. 22:448 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1; Acts 2012, No. 544, § 3.

§ 178. 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.

Renumbered from R.S. 22:449 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 179. 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.

Renumbered from R.S. 22:450 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 180. Annual statements

The annual statement of a reciprocal insurer shall be made and filed by the attorney-in-fact.

Renumbered from R.S. 22:451 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 181. Reserves

Each reciprocal insurer subject to this Subpart 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.

Renumbered from R.S. 22:452 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 182. 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. 22:168.

Renumbered from R.S. 22:453 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 183. Application for receiver

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 R.S. 22:73, 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq.

Renumbered from R.S. 22:454 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 184. Penalties

No person shall act as attorney-in-fact for a reciprocal insurer except in accordance with the provisions of this Subpart 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.

Renumbered from R.S. 22:455 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 185. Application of other sections

Except as otherwise provided in this Subpart, every reciprocal insurer shall be subject to other applicable provisions of this Code.

Renumbered from R.S. 22:456 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

SUBPART G. NONPROFIT FUNERAL SERVICE ASSOCIATIONS

§ 191. Definitions

For the purposes of this Subpart, the terms stated in this Section have the meanings assigned to them, respectively, unless the context otherwise requires:

(1) "Nonprofit funeral service association" or "nonprofit association" means a corporation organized, incorporated, and operated under the provisions of this Subpart which furnishes to its policyholders funeral services, supplies, and other benefits hereinafter authorized on the assessment or cooperative 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 any other fraternal benefit society organized and qualified prior to 12:00 noon, October 1, 1948.

(2) "Policyholder" means any person who is named as a beneficiary in a policy or certificate of membership issued by a nonprofit funeral association.

(3) "Insured bank" means a bank, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(4) "Funeral services and supplies" means the general and usual services rendered and supplies furnished by undertakers, embalmers, and funeral directors.

Renumbered from R.S. 22:331 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 192. Incorporation and qualification of incorporators

A. (1) Five or more natural persons who are residents of this state of full age, or fully relieved by emancipation of all disabilities attaching to minority, may form a nonprofit corporation, under the provisions of this Subpart, having for its purpose the establishing, maintaining, and operating of a nonprofit funeral service plan.

(2) 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.

B. All associations now operating and authorized under this Subpart, 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 five hundred dollars, 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 Subpart and by all the applicable provisions of this Code.

Renumbered from R.S. 22:332 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 193. Articles of incorporation

A. 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 nonprofit 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 and the names and post office addresses and respective titles of the first officers.

(7) Provisions for meetings at least annually of the policyholders.

B. In addition to the information specified in Subsection A of this Section, the articles may contain any provision creating, defining, dividing, limiting, or regulating the powers of the directors, officers, or policyholders or any other provisions not inconsistent with this Subpart or the laws of this state for the carrying out of the purposes and the conduct of the affairs of the association.

Renumbered from R.S. 22:333 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 194. The corporate name

A. The corporate name must end with the words "Funeral Association" or the words "Funeral Association Incorporated" or the words and abbreviation "Funeral Association, Inc."

B. 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.

Renumbered from R.S. 22:334 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 195. 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 Subpart, 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. 22:64.

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 bylaws 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 bylaws, 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 bylaws.

(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. 22:64 shall be complied with.

Renumbered from R.S. 22:335 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 196. Application for policies

A. 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 producer may sign any application which he has not personally solicited or received.

B. 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, and 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 bylaws.

C. 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.

D. 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 bylaws 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.

E. 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.

Renumbered from R.S. 22:336 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 197. Policies

A. Every policy issued by any association authorized under this Subpart shall have plainly printed on the first page thereof the words "Assessment or Cooperative 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 Subpart shall be incontestable after one year from the date of its issue except for nonpayment of assessments.

Renumbered from R.S. 22:337 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1999, No. 1304, § 1, eff. July 12, 1999; Acts 2009, No. 503, § 1.

§ 198. Bylaws

A. The board of directors of an association authorized under this Subpart may make and alter bylaws not inconsistent with the law or articles. The initial bylaws filed with the articles shall be signed by the first directors named in the articles.

B. The bylaws of all associations authorized under this Subpart 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.

C. The bylaws 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.

Renumbered from R.S. 22:338 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 199. Amendment of articles and bylaws

A. 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. 22:67.

B. The board of directors may at any regular or special meeting adopt amendments to the bylaws, 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 shall 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.

Renumbered from R.S. 22:339 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 200. Directors

A. Subject to such limitations, restrictions, or reservations as may be provided in the articles, the bylaws, or this Subpart, 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 shall be policyholders in good standing.

B. The number, qualifications, terms of office, manner of election, time and place of and manner of calling and holding meetings, powers and duties, and method of and cause for removal of directors may, subject to the provisions of this Subpart, be prescribed by the articles or bylaws.

C. 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 Subpart upon the board.

Renumbered from R.S. 22:340 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 201. Officers and directors

A. 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 these officers may be combined in one person and should the office of treasurer and another one of the officers be combined in one person, that officer need not be a member of the board of directors. The treasurer may be a member of the board.

B. The president shall be ex officio chairman of the board of directors. He

shall preside at all meetings of the board and at all meetings of the policyholders and shall perform such other duties and functions as are required or permitted by this Subpart and the provisions of the articles. In the absence of the president, the vice-president shall act in his place and stead.

C. 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 Subpart and the provisions of the articles.

D. The qualifications, terms of office, manner of election, and the powers and duties of the officers may, subject to the provisions of this Subpart, be prescribed by the articles or bylaws. No person shall solicit, write, or issue any policy under this Subpart without having first been duly licensed by the commissioner of insurance as a producer.

Renumbered from R.S. 22:341 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 202. Policyholders' meetings

A. Meetings of the policyholders shall be held at such times and places as the articles and bylaws may provide but the articles and bylaws shall provide for the manner of calling and the notice to be given of special meetings of the policyholders. The articles or bylaws 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.

B. 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.

C. 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.

Renumbered from R.S. 22:342 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 203. Funds

A. All funds of every association operating under this Subpart 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, except 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 Subpart.

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 reserve 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.

Renumbered from R.S. 22:343 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1981, No. 856, § 1; Acts 1993, No. 784, § 1.

§ 204. 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 bylaws 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 bylaws of the association.

Renumbered from R.S. 22:344 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 205. 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 Subpart, 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.

Renumbered from R.S. 22:345 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1964, No. 152, § 1; Acts 1981, No. 386, § 1, eff. Jan. 1, 1982.

§ 206. Expenses

The expenses of necessary printing, stationery, postage, office supplies and expenses, clerical hire, statutory fees, and examination fees may be paid by the association. The total of all expenses shall not exceed twenty-five percent of each assessment and shall be paid out of the general fund of the association.

Renumbered from R.S. 22:346 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 207. 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.

Renumbered from R.S. 22:347 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 208. 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 Subpart, the articles and bylaws. 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.

Renumbered from R.S. 22:348 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 209. 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 Subpart or its articles or bylaws.

Renumbered from R.S. 22:349 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1997, No. 1449, § 1.

§ 210. 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 thirty-first 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.

Renumbered from R.S. 22:350 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 211. Expiration of certificate of authority; renewal

Every certificate of authority issued by the commissioner of insurance to any association shall continue in force until the thirty-first 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 Subpart.

Renumbered from R.S. 22:351 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 212. Merger and consolidation

A. Any two or more associations operating under this Subpart 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.

B. 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.

C. In addition to the other requirements of this Section, any association incorporated or hereinafter incorporated under the provisions of this Subpart may with the consent of the board of directors and any other association or corporation operating a nonprofit funeral association other than under the provisions of this Subpart by and with the consent of the officers or board of directors of the other association or corporation, as provided for under the bylaws, 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 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 Subpart, and by and under the name of the association incorporated under the provisions of this Subpart.

Renumbered from R.S. 22:352 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 213. Liquidation

A. Whenever the board of directors of any association operating under this Subpart 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 Subpart, 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 Subpart, the articles, or bylaws.

B. Whenever it appears to the commissioner of insurance that any association is failing to comply with the provisions of this Subpart or its articles or bylaws 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 R.S. 22:73, 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq.

Renumbered from R.S. 22:353 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 214. Fees payable

Every nonprofit funeral service association shall pay the following fees:

(1) To the secretary of state:

(a) For filing and recording articles, twenty-five cents per one hundred words.

(b) For certificate of recordation, one dollar.

(2) To the commissioner of insurance:

(a) For each certificate of authority, twenty-five dollars.

(b) For each examination, not exceeding twenty-five dollars per diem and expenses for each examiner.

(c) For each producer's license, two dollars.

Renumbered from R.S. 22:354 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 215. Exemption from taxation

All nonprofit 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. 22:214, by the state or any of its political subdivisions.

Renumbered from R.S. 22:355 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 216. 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 Subpart 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 a producer without having been duly licensed as provided in this Subpart 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 producer of any association embraced within the provisions of this Subpart who shall wilfully commit any of the following acts and any officer, director, or producer of any such association who shall wilfully condone or acquiesce in any of these 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 six months or both at the discretion of the court:

(1) Soliciting or receiving any application which does not comply with R.S. 22:196(A) or (B).

(2) Failing to retain the original applications for policies as required by R.S. 22:196(C) .

(3) Issuing any policy which does not comply with R.S. 22:197.

(4) Failing to maintain the reserve fund required by R.S. 22:203.

(5) Withdrawing any funds of such association in any other manner than is specifically authorized in this Subpart.

(6) Issuing any policy or make or cause to be made any assessment not provided for or authorized by R.S. 22:205.

(7) Failing to maintain books or records as required by R.S. 22:208.

(8) Refusing to any duly authorized representative of the office of the commissioner of insurance access to the books and records of the association.

(9) Failing to file or failing to file within the required time the reports required by R.S. 22:210.

(10) Making or causing 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.

(11) Making or causing 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.

(12) Failing 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.

(13) Failing to include in any assessment any policyholder who has received a policy more than sixty days prior to such assessment.

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 Subpart; 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 Subpart 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.

Renumbered from R.S. 22:356 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

SUBPART H. MUTUAL INSURANCE HOLDING COMPANIES

§ 231. 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. 22:691 et seq., the Insurance Holding Company System Regulatory Law.

Renumbered from R.S. 22:820 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1.

§ 232. Applicability of demutualization provisions

R.S. 22:71 and 72 are applicable to a demutualization of a mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company reorganized under this Subpart as if it were a mutual insurance company. R.S. 22:71 and 72 are not applicable to a reorganization or merger pursuant to this Subpart.

Renumbered from R.S. 22:821 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1.

§ 232.1. Mutual insurance holding company plan of reorganization

A. An insurer seeking to reorganize under R.S. 22:231 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 Subpart.

(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.[1]

B. The commissioner, after a public hearing as provided in R.S. 22:694(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. 22:231 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. 22:694(D)(3). A reorganization pursuant to R.S. 22:231 is subject to the provisions of R.S. 22:694(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.

Redesignated from R.S. 22:695 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1.

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

§ 232.2. 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. 22:231 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. 22:62 or 67 and shall be subject to prior approval of the commissioner in the same manner as those of a domestic incorporated insurer.

(2) After approval of the commissioner, the articles showing the approval of the commissioner shall be filed in the office of the secretary of state 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 Paragraph (5) of this Subsection as soon as they have been selected.

(3) 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 Subpart and Title 12 of the Louisiana Revised Statutes of 1950, 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 issue a certificate of incorporation that shall show the date. 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 mutual insurance holding company or an intermediate holding company, the certificate of incorporation shall be only prima facie evidence of due incorporation.

(4) 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.

(5) 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.

B. The commissioner shall retain jurisdiction over a mutual insurance holding company and an intermediate holding company established pursuant to R.S. 22:231 to protect policyholders' interests, and the mutual insurance holding company shall be subject to the requirements of this Subpart and the Insurance Holding Company System Regulatory Law, R.S. 22:691 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. 22:231, shall be subject to the limitations of Subpart B of this Part 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 Parts I and III of Chapter 3 of this Title, R.S. 22:791 et seq. and R.S. 22:821 et seq., and R.S. 22:831 through 838 and 842 through 846 for the purposes of R.S. 22:791.

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. 22:119 through 121 and a written proxy conferred upon another policyholder either prior to, contemporaneously with, or after a reorganization under R.S. 22:231, 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.

Redesignated from R.S. 22:696 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1. Amended by Acts 2009, No. 503, § 1; Acts 2010, No. 730, § 1, eff. June 29, 2010.

§ 232.3. 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. 22:231 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. 22:694(D), may approve the proposed merger. The commissioner may retain consultants as provided in R.S. 22:694(D)(3). A merger pursuant to this Section is subject to R.S. 22:694(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. 22:695(D) shall apply to a merger authorized under this Section.

Redesignated from R.S. 22:697 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997,

No. 1482, § 1.

§ 232.4. Capital stock of a reorganized insurance company

A. (1) A mutual insurance holding company established pursuant to R.S. 22:231 shall at all times own a majority of the voting shares of the capital stock of insurance companies reorganized under R.S. 22:231.

(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. 22:691 et seq., any dividends paid by an insurance company reorganized pursuant to R.S. 22:231 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. 22:231 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,[1] and Book V, Summary and Executory Proceedings,[2] 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.

Redesignated from R.S. 22:698 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1997.

[1] C.C.P. art. 2251 et seq.

[2] C.C.P. art. 2591 et seq.

§ 232.5. Insurer's rehabilitation and liquidation

A mutual insurance holding company established pursuant to R.S. 22:231 is deemed to be an insurer subject to R.S. 22:73 and 96, Subpart H of this Part, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq., 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. 22:231, is a subsidiary of the mutual insurance holding company or an intermediate holding company. In any proceeding under R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Title involving an insurance company reorganized under R.S. 22:231, 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Title.

Redesignated from R.S. 22:699 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1. Amended by Acts 2009, No. 503, § 1.

§ 232.6. Applicability; membership interests

A membership interest in a domestic mutual insurance holding company established under R.S. 22:231 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.[1]

Redesignated from R.S. 22:700 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1.

[1] R.S. 51:701 et seq.

§ 232.7. Sale of stock

An intermediate holding company established and an insurance company reorganized pursuant to R.S. 22:231 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. 22:698. 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. 22:231 or the intermediate holding company established under R.S. 22:231 may be made except in accordance with the provisions of R.S. 22:88.

Redesignated from R.S. 22:701 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1. Amended by Acts 2009, No. 503, § 1.

§ 232.8. Failure to give notice

If the mutual insurance company complies substantially and in good faith with the notice requirements of R.S. 22:695, 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. 22:231 or this Subpart.

Redesignated from R.S. 22:702 by Acts 2012, No. 294, § 3. Renumbered from R.S. 22:1004.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1482, § 1.

SUBPART H-1. CONVERSIONS OF MUTUAL LIFE INSURERS AND MUTUAL LIFE INSURANCE HOLDING COMPANIES

§ 236. Definitions

As used in this Subpart, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "Adoption date" means the date as of which the board of directors of the reorganizing mutual initially approves and adopts the plan of reorganization.

(2) "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.

(3) "Commissioner" means the commissioner of insurance, or his deputy, or the Department of Insurance, as appropriate.

(4) "Control" has the meaning set forth in R.S. 22:692[1].

(5) "Dividend protections" means provisions in a plan of reorganization designed to protect, through a closed block or other means, the reasonable dividend expectations of policyholders who own individual, dividend-paying policies.

(6) "Effective date" means the date upon which the reorganization of the reorganizing mutual is effective, as provided in R.S. 22:236.8.

(7) "Eligible member" means a person who, on the adoption date, owns, or is deemed by the plan of reorganization to own, a policy of a mutual insurer or a reorganized insurer that is, or that is deemed by the plan of reorganization to be, in force with such insurer on such adoption date, or a person who is deemed

eligible by the plan of reorganization.

(8) "Member" means: (a) with respect to a mutual insurer, a policyholder who owns or is deemed by the plan of reorganization to own a policy of the mutual insurer; or (b) with respect to a mutual insurance holding company, a member of such mutual insurance holding company, as defined in such company's articles of incorporation and bylaws or as defined in the plan of reorganization.

(9) "Membership interest" means: (a) with respect to a mutual insurer, all rights and interests of a policyholder as a member arising under the mutual insurer's articles of incorporation and bylaws, by law or otherwise, which rights include but are not limited to the right, if any, to vote and the right, if any, with regard to the surplus of the mutual insurer not apportioned or declared by the board of directors for policyholder dividends; or (b) with respect to a mutual insurance holding company, all rights and interests of the member arising under the mutual insurance holding company's articles of incorporation and bylaws, by law or otherwise, which rights include but are not limited to the right, if any, to vote and the right, if any, to receive consideration upon the demutualization or liquidation of the mutual insurance holding company.

(10) "Mutual insurance holding company" and "mutual life insurance holding company" both mean a domestic mutual holding company formed as a result of the conversion of a mutual insurer as defined in this Subpart pursuant to R.S. 22:231 and 691 et seq. in accordance with a plan of reorganization approved by the commissioner.

(11) "Mutual insurer" and "mutual life insurer" both mean for purposes of this Subpart a domestic mutual insurer subject to Subpart C of this Part, R.S. 22:111 et seq., that is authorized to transact life, or life and accident and health insurance in this state, but does not mean a domestic nonprofit mutual association as described in R.S. 22:124.

(12) "Parent corporation" means a stock corporation that is or has been organized for the purpose of acquiring, directly or indirectly, all of the common shares of a reorganized insurer.

(13) "Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a limited liability company, a limited liability partnership, a government or governmental agency, a state or political subdivision of a state, board, estate, trustee or fiduciary, or any other legal entity.

(14) "Plan of reorganization" means the plan of reorganization adopted by the reorganizing mutual in compliance with this Subpart.

(15) "Policy" means an individual or group policy of insurance or annuity contract issued, or deemed by the plan of reorganization to have been issued, by a mutual insurer or by a reorganized insurer. If a policy is a group policy, the individual certificates or other evidences of interests in the group policy shall not be treated as separate policies; however, in the case of a policy or contract that was issued to a trust or group established or deemed by the plan of reorganization to have been established by the mutual insurer or the reorganized insurer, the reorganizing mutual may provide in its plan of reorganization that each certificate or other evidence of interest is deemed to be a policy for the

sole purpose of determining the rights, if any, of the holders of those certificates to receive consideration under the plan of reorganization.

(16) "Policyholder" means a person who, on the basis of the records and the organizational documents of the mutual insurer or reorganized insurer, is deemed to be a policyholder of such insurer.

(17) "Qualified voter" is a member of the reorganizing mutual that is entitled to vote on matters coming before corporate meetings of the reorganizing mutual pursuant to its articles of incorporation and bylaws.

(18) "Reorganized company" means either: (a) a reorganized insurer resulting from the reorganization of a mutual insurer under this Subpart; or (b) a reorganized insurance holding company.

(19) "Reorganized insurance holding company" means a former mutual insurance holding company reorganized as a stock insurance holding company, or a stock insurance holding company into which a mutual insurance holding company has been merged, pursuant to a plan of reorganization under this Subpart.

(20) "Reorganized insurer" means: (a) with respect to a conversion of a mutual insurer under this Subpart, the domestic stock insurer into which a mutual insurer is being or has been reorganized; or (b) with respect to the conversion of a mutual insurance holding company under this Subpart, any former mutual insurance company previously reorganized as a stock insurance company as part of a mutual insurance holding company reorganization under R.S. 22:231 and 695 or under the mutual insurance holding company laws of another state.

(21) "Reorganizing mutual" means a mutual insurer or mutual insurance holding company that is reorganizing pursuant to this Subpart.

Renumbered from R.S. 22:822 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008. Amended by Acts 2009, No. 503, § 1; Acts 2010, No. 730, § 1, eff. June 29, 2010.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 236.1. Conversion of mutual insurers and mutual insurance holding companies authorized

A. A mutual insurer may, pursuant to R.S. 22:71 and 72 and to the provisions of this Subpart, reorganize into a stock insurance company that may be or become a subsidiary of a parent corporation that is or has been formed for the purpose of acquiring, directly or indirectly, all of the common stock of such reorganized insurer.

B. A mutual insurance holding company may, pursuant to the provisions of this Subpart, reorganize into a stock insurance holding company.

Renumbered from R.S. 22:823 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.2. Plan of reorganization

A. A reorganizing mutual seeking to reorganize pursuant to the provisions of this Subpart shall submit a proposed plan of reorganization to the commissioner. The plan of reorganization shall include the following:

(1) A statement analyzing the benefits and risks attendant to the proposed reorganization, including the rationale for the reorganization.

(2) A statement indicating how the reorganization will protect the immediate and long-term interests, and serve the best interests of policyholders.

(3) Copies of the articles of incorporation and bylaws of the reorganized company and any affiliate parent corporation, stockholding companies, and reorganized insurers.

(4) Information sufficient to demonstrate that the financial condition of any reorganized insurer will not be diminished upon reorganization.

(5) A description of any plans for the initial sale of stock of the reorganizing mutual or any parent corporation or affiliate stockholding company.

B. The plan of reorganization shall:

(1) Provide that all membership interests in the reorganizing mutual shall be extinguished as of the effective date.

(2) Require the distribution of consideration, in a fair and equitable manner, to all eligible members upon extinguishment of the membership interests.

(3) Specify the manner in which the aggregate value of the consideration shall be determined and the method by which the consideration shall be allocated among eligible members.

(4) Provide dividend protections for the reasonable dividend expectations of policyholders of any reorganized insurer, all as set forth in R.S. 22:236.3.

C. The plan of reorganization shall have been duly adopted by action of not less than two-thirds of the members of the entire board of directors of the reorganizing mutual.

D. A plan of reorganization filed with the commissioner pursuant to this Section shall be accompanied by the proposed forms of notice required by R.S. 22:236.4(C) and 236.5(C).

E. All information, documents, and copies thereof obtained by or disclosed to the commissioner, the Department of Insurance, or its designated representative in the course of an examination of a proposed plan of reorganization shall be treated in accordance with R.S. 22:706.

Renumbered from R.S. 22:824 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.3. Consideration and dividend protections

A. In effecting a conversion of a reorganizing mutual, each eligible member shall

be entitled to consideration in an amount equal to his or its equitable share of the value of the reorganizing mutual as provided for in the plan of reorganization, as follows:

(1) The consideration to be distributed to eligible members may consist of cash, stock of the reorganized company or its parent corporation, or if appropriate for tax or other reasons, additional life insurance and annuity benefits, any combination of these forms of consideration, or other forms of consideration acceptable to the commissioner. The form or forms of consideration to be distributed to an eligible member may differ according to the class or category of policy owned by the eligible member. The choice of the form or forms of consideration to be distributed to eligible members in accordance with the class or category of policy owned by such members may take into account such factors as the type of policy with respect to which the consideration is being distributed and the amount being distributed with respect to such policies, the country of residence, or tax status of the member or other appropriate factors; however, if the consideration to be distributed to an eligible member will be in a form other than common stock of a publicly traded company, the plan of reorganization shall include provisions for determining, in a reasonable manner, the value of the consideration by means of reference to the per share public market value of the registered common stock of the reorganized company or its parent corporation or another method acceptable to the commissioner.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from a qualified investment banker that the provision of consideration upon the extinguishment of the membership interests pursuant to the plan of reorganization is fair to the eligible members, as a group, from a financial point of view.

B. The method of allocating consideration among eligible members shall be fair and equitable, as follows:

(1) The method shall provide for each eligible member to receive: (a) a fixed component of consideration or a variable component of consideration, or both; or (b) any other component of consideration acceptable to the commissioner. Components may reflect, based upon fair and equitable formulas, methods, and assumptions, factors such as estimated proportionate historical and prospective contributions to surplus of classes or groupings of policies and contracts to the aggregate component of consideration being distributed to eligible members, with each eligible member receiving a distribution in accordance with the type of policy owned by the eligible member, or other factors the commissioner may approve.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from an actuary who is a member of the American Academy of Actuaries that the methodology and underlying assumptions for allocation of consideration among eligible members are reasonable and appropriate and the resulting allocation is fair and equitable.

C. At the option of the reorganizing mutual, any shares of the reorganized insurer or its parent corporation included in the eligible members' consideration may be placed on the effective date of the reorganization in a trust or other entity existing for the exclusive benefit of eligible members and established for the purpose of effecting the reorganization, such consideration or the proceeds of

the sale of such consideration to be distributed to such eligible members by means of a process specified in the plan of reorganization and not to last more than twenty-one years after the effective date of the reorganization or until notification of the death of the eligible member or the death of the insured, whichever occurs first.

D. (1) The plan of reorganization shall provide for the reasonable dividend expectations of policyholders of any reorganized insurer through the establishment, or in the case of a reorganizing mutual insurance holding company the continuation, of dividend protections, which may consist of a closed block or any other method acceptable to the commissioner. The sole purpose of any dividend protections shall be to provide for reasonable policyholder dividend expectations.

(2) Any dividend protections provision may be limited to participating individual life insurance policies and participating individual annuity contracts in force or deemed to be in force by the plan of reorganization on the effective date of the reorganization, or, in the case of a reorganized insurer in a mutual insurance holding company system, on the effective date of its reorganization as such, for which the insurer has or had an experience-based dividend scale due, paid or accrued by action of the board of directors of the insurer in the year in which the plan of reorganization is or was adopted; however, other categories of policies and benefits not described in this Paragraph may be included or excluded, subject to the approval of the commissioner.

(3) In the event that dividend protections have been provided to policyholders of a reorganized insurer as part of a previous plan of reorganization, such dividend protections may be continued in effect without change in satisfaction of the requirements of this Section.

Renumbered from R.S. 22:825 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008. Amended by Acts 2009, No. 503, § 1; Acts 2010, No. 730, § 1, eff. June 29, 2010.

§ 236.4. Approval by commissioner after public hearing

A. The commissioner shall hold a public hearing upon notice as set forth in this Section to hear evidence upon whether the plan of reorganization: (1) properly protects the interests of the policyholders as such and as members, (2) serves the best interests of policyholders and members, and (3) is fair and equitable to policyholders and members. Subpart G of Part III of this Chapter, R.S. 22:691 et seq., is not applicable to any hearing held under this Subpart, and any such hearing shall be governed by the procedures set forth herein.

B. (1) Within thirty days after the closing of the administrative record after the public hearing as provided in this Section, the commissioner shall issue a final order or decision approving the plan if satisfied that each of the following conditions are met:

(a) The interests of the policyholders as such and as members are properly protected.

(b) The plan of reorganization serves the best interests of policyholders and members.

(c) The plan of reorganization is fair and equitable to policyholders and members.

(2) Any such final decision or order by the commissioner shall be subject to any modifications of the plan of reorganization the commissioner finds necessary for the protection of the policyholders and members.

C. Subject to the review and appeal process provided in Subsection E of this Section, the commissioner's public hearing shall be the exclusive hearing with respect to the plan of reorganization. Not less than thirty days notice of such public hearing shall be provided by the reorganizing mutual to qualified voters and to such additional persons and in such manner as may be specified by the commissioner. The commissioner may promulgate procedures, rules, and regulations for the conduct of the public hearing.

D. The commissioner may retain at the reorganizing mutual's expense such attorneys, actuaries, accountants, and other experts as may be reasonably necessary to assist the commissioner in his examination of a proposed conversion, including any part of such examination that may occur, at the request of a reorganizing mutual, prior to a plan of reorganization having been filed with the commissioner pursuant to R.S. 22:236.2. Such experts must prepare a projection of the amount of time and expenses necessary to complete the examination, and all work of these experts is subject to review. If the projected amount of time and expenses required to complete the examination appear excessive, the reorganizing mutual may petition the commissioner for appropriate relief, and the commissioner's decision shall be final.

E. (1) An aggrieved party may appeal the commissioner's final order to the Nineteenth Judicial District Court within thirty days of the order. The aggrieved party may also apply for a stay of the commissioner's order.

(2) The district court reviewing an order of the commissioner shall consider only the certified administrative record and the issues raised before the commissioner. The district court reviewing an order of the commissioner shall not modify or set aside the order unless the court finds: (a) error to the prejudice of the appellant's substantial rights arising from the commissioner's application of the law so grossly as necessarily to imply bad faith; (b) the commissioner's order or decision was procured by fraud; (c) the commissioner acted outside of the statutory authority of the Department of Insurance; or (d) the commissioner's action was arbitrary and capricious. Any appeal of the district court's review of the commissioner's order shall be taken within thirty days of the judgment of the district court; if not so taken, the right to have an appellate court review or restrain action under the commissioner's order or decision shall be preempted and shall forever expire. Collateral attacks on an order of the commissioner are impermissible and shall be dismissed by the reviewing court.

(3) In any action challenging the validity of or arising out of any action taken or proposed to be taken under this Subpart, the reorganizing mutual or reorganized company shall be entitled at any stage of the proceedings before final judgment to petition the court to require the plaintiff or plaintiffs to give security for the reasonable costs, including attorney fees, which may be incurred by the reorganizing mutual or reorganized company, to which security the reorganizing mutual or reorganized company shall have recourse in such amount as the court

having jurisdiction of such action shall determine upon termination of such action. The amount of security may thereafter from time to time be increased or decreased in the discretion of the court having jurisdiction of such action upon a showing that the security provided has or may become inadequate or excessive. If the court renders judgment in favor of the reorganizing mutual or reorganized company, the court may in its discretion award attorney fees and costs to such prevailing party.

F. The provisions of this Section shall apply to all actions challenging the validity of or arising out of any action taken or proposed to be taken under this Subpart and R.S. 22:71 and 72.

Renumbered from R.S. 22:826 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 236.5. Approval by qualified voters

A. The plan of reorganization shall be approved at a meeting convened for that purpose by a vote of not less than two-thirds of the qualified voters of the reorganizing mutual entitled to vote on matters and present or represented by special ballot or special proxy.

B. The meeting of qualified voters to consider the plan of reorganization shall occur after the public hearing before the commissioner, and the closing of the administrative record after the public hearing shall not occur until such time as it includes certification by the reorganizing mutual to the commissioner of the vote on the plan of reorganization by the qualified voters of the reorganizing mutual.

C. All qualified voters shall be given notice of their opportunity to vote on the plan of reorganization, which notice shall include a copy of the plan of reorganization or a summary thereof and which shall be in a form that the commissioner has determined is adequate and may be provided to qualified voters. The notice may be combined with notice of the public hearing. The notice shall be mailed, or provided by some other method or methods as may be approved by the commissioner, not less than thirty days before the date of the meeting of qualified voters to vote on the plan of reorganization. If the reorganizing mutual complies substantially and in good faith with the notice requirements of this Section, the failure of any person to actually receive any required notice will not impair the validity of any action taken under this Subpart.

D. A quorum for the meeting of qualified voters to consider the plan of reorganization shall consist of the qualified voters present or represented by special ballot or special proxy.

E. Voting, ballot, and proxy submission may take place electronically or telephonically consistent with the requirements of the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq.

Renumbered from R.S. 22:827 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.6. Limitations on acquisition of beneficial ownership

A. Except as otherwise specifically provided in the plan of reorganization, prior to and for a period of five years following the effective date of the reorganization, no person or persons acting in concert, other than the reorganized company or any employee benefit plans or trusts sponsored by the reorganized company or its corporate affiliates, shall directly or indirectly offer to acquire or acquire in any manner the beneficial ownership of five percent or more of any class of a voting security of the reorganized company or any person that owns or controls a majority or all of the voting securities of the reorganized company without the prior approval by the commissioner of an application for acquisition filed by that person with the commissioner.

B. The commissioner shall not approve an application for acquisition unless he finds each of the following:

(1) The acquisition would not frustrate the plan of reorganization as approved by the qualified voters and the commissioner.

(2) The board of directors of the reorganized company or its parent corporation, as applicable, has approved the acquisition, or extraordinary circumstances not contemplated in the plan of reorganization have arisen that would warrant their approval of the acquisition.

(3) The acquisition would be in the best interest of the reorganized company and policyholders of the reorganized insurer or insurers. In determining whether an acquisition would be in the best interest of the reorganized company and policyholders of the reorganized insurer or insurers, the commissioner may consider such factors as he deems relevant, which may but are not required to include any or all of the following: (a) the possible effects on shareholders, employers, suppliers, creditors, and customers of the reorganized company and its affiliates; (b) possible effects on the economy of the communities in which the reorganized company is located, and on that of this state; and (c) company and policyholders of the reorganized insurer or insurers, including but not limited to the possibility that those interests may be best served by the continued independence of the reorganized company.

C. No security that is the subject of any agreement or arrangement regarding acquisition or that is acquired or to be acquired in contravention of this Section or of an order of the commissioner may be voted at any shareholders' meeting, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; however, no action taken at a meeting shall be invalidated by the voting of those securities unless the action would materially affect control of the reorganized insurer or a person that owns or controls a majority or all of the voting securities of the reorganized insurer or unless the courts of this state have so ordered.

Renumbered from R.S. 22:828 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.7. Limitations on compensation of directors, officers, agents, and employees

Except as set forth in the plan of reorganization approved by the qualified

voters and the commissioner or in a stock-based compensation program or arrangement using options or other securities previously registered with the commissioner pursuant to R.S. 22:88 or any successor statute, no director, officer, agent, or employee of the reorganizing mutual shall receive any fee, commission, or other valuable consideration, other than his usual regular salary and compensation, that is contingent upon the plan of reorganization becoming approved or effective or is based upon aiding, promoting, or assisting in the approval or effectuation of the plan of reorganization. This Section shall not prohibit compensation programs or arrangements including programs and arrangements involving the use of the stock of the reorganized company or its parent corporation, which are to become effective simultaneously with the plan of reorganization or thereafter, provided such programs and arrangements are contained in the plan of reorganization approved by the qualified voters and the commissioner or in a program or arrangement using options or other securities previously registered with the commissioner pursuant to R.S. 22:88 or any successor statute. This Section shall not be deemed to prohibit such a program or arrangement from being adopted after the effective date of a reorganization.

Renumbered from R.S. 22:829 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.8. Filing of certificate of compliance; effective date of reorganization

A. On or prior to the effective date of the reorganization, the reorganizing mutual shall file with the commissioner a certificate stating that:

(1) All of the conditions set forth in the plan of reorganization, including a final order by the commissioner granting permission to reorganize in accordance with the plan of reorganization pursuant to R.S. 22:236.4 and approval by qualified voters pursuant to R.S. 22:236.5, have been satisfied.

(2) The board of directors of the reorganizing mutual has not abandoned the plan of reorganization.

B. Notwithstanding anything in R.S. 12:23, the articles of incorporation of the reorganizing mutual shall be approved and recorded in accordance with the provisions of R.S. 22:63 and 64.

C. The reorganization shall be effective upon the date and hour certified by the commissioner, which shall be the later of: (1) the date and hour when the articles of incorporation were filed for record in the office of the proper recorder of mortgages; or (2) such other date and time specified in the articles of incorporation as the date and hour when the reorganization shall be effective, which shall not be later than the tenth day after the date the articles of incorporation are recorded.

Renumbered from R.S. 22:830 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008. Amended by Acts 2010, No. 730, § 1, eff. June 29, 2010.

§ 236.9. Effect of reorganization

A. With respect to the conversion of a mutual insurer, upon the effective date, the mutual insurer shall immediately become a stock insurer, all membership

interests shall be extinguished, and the reorganized insurer or its parent corporation will act in good faith to convey consideration to eligible members pursuant to the plan of reorganization. The reorganized insurer shall be a continuation of the mutual insurer, and the reorganization in no way shall annul, modify, or change any of the mutual insurer's existing suits, rights, contracts, or liabilities, except as provided in the plan of reorganization. After reorganization, the reorganized insurer shall exercise all the rights and powers and perform all the duties conferred or imposed by law upon insurers writing the classes of insurance written by it, and shall be vested in all the rights, franchises, and interests of the mutual insurer in and to every species of property without any deed or transfer, and the reorganized insurer shall succeed to all the obligations and liabilities of the mutual insurer, and retain all rights and contracts existing prior to conversion, except as provided in the plan of reorganization.

B. With respect to the conversion of a mutual insurance holding company, upon the effective date, the membership interests of the members of the mutual insurance holding company shall be extinguished, and the reorganized company shall act in good faith to convey consideration to eligible members pursuant to the plan of reorganization. Each reorganized insurer within the mutual insurance holding company system will continue its corporate existence as a stock insurer within a stock insurance holding company system, and the reorganization shall in no way annul, modify, or change any of such reorganized insurer's existing suits, rights, contracts, or liabilities, except as provided in the plan of reorganization.

Renumbered from R.S. 22:831 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.10. Abandoning or amending plan of reorganization

The reorganizing mutual may, by action of not less than two-thirds of its board of directors, abandon or amend the plan of reorganization at any time before the effective date. No amendment made after the public hearing required by R.S. 22:236.4 shall change the plan of reorganization in a manner which the commissioner determines is materially disadvantageous to policyholders or members unless a further public hearing is held on the plan as amended.

Renumbered from R.S. 22:832 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

§ 236.11. Directors and officers of the reorganized company

The directors and officers of the reorganizing mutual, unless otherwise specified in the plan of reorganization, shall serve as the directors and officers of the reorganized company until new directors and officers are duly elected pursuant to the articles of incorporation and bylaws of the reorganized company.

Renumbered from R.S. 22:833 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 307, § 1, eff. June 17, 2008.

SUBPART H-2. CONVERSIONS OF DOMESTIC MUTUAL NON-LIFE INSURERS AND MUTUAL INSURANCE HOLDING COMPANIES

§ 237. Corporate reorganization

The conversion of a mutual non-life insurer or a mutual non-life insurance holding company pursuant to R.S. 22:71 and 72 shall also comply with the provisions of this Subpart. "Mutual non-life insurer" and "mutual non-life insurance holding company" shall have the meanings as set forth in R.S. 22:237.2.

Added by Acts 2009, No. 234, § 1.

§ 237.1. Applicability of provisions

The provisions of R.S. 22:71 and 72 shall apply to a demutualization of a mutual non-life insurance holding company which resulted from the reorganization of a domestic mutual non-life insurance company reorganized pursuant to R.S. 22:231 as if it were a mutual life insurance company.

Added by Acts 2009, No. 234, § 1.

§ 237.2. Definitions

As used in this Subpart, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "Adoption date" means the date as of which the board of directors of the reorganizing mutual initially approves and adopts the plan of reorganization.

(2) "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.

(3) "Commissioner" means the commissioner of insurance, or his deputy, or the Department of Insurance, as appropriate.

(4) "Control" means the same as that set forth in R.S. 22:692[1].

(5) "Dividend protections" means provisions in a plan of reorganization designed to protect, through a closed block or other means, the reasonable dividend expectations of policyholders who own individual, dividend-paying policies.

(6) "Effective date" means the date upon which the reorganization of the reorganizing mutual is effective, as provided in R.S. 22:237.10.

(7) "Eligible member" means a person who, on the adoption date, owns, or is deemed by the plan of reorganization to own, a policy of a mutual insurer or a reorganized insurer that is, or that is deemed by the plan of reorganization to be, in force with such insurer on such adoption date, or a person who is deemed eligible by the plan of reorganization.

(8) "Member" means: (a) with respect to a mutual insurer, a policyholder who owns or is deemed by the plan of reorganization to own a policy of the mutual insurer; or (b) with respect to a mutual insurance holding company, a member of such mutual insurance holding company, as defined in such company's articles of incorporation and bylaws or as defined in the plan of reorganization.

(9) "Membership interest" means: (a) with respect to a mutual insurer, all rights and interests of a policyholder as a member arising under the mutual insurer's articles of incorporation and bylaws, by law or otherwise, which rights include but are not limited to the right, if any, to vote and the right, if any, with regard to the surplus of the mutual insurer not apportioned or declared by the board of directors for policyholder dividends; or (b) with respect to a mutual insurance holding company, all rights and interests of the member arising under the mutual insurance holding company's articles of incorporation and bylaws, by law or otherwise, which rights include but are not limited to the right, if any, to vote and the right, if any, to receive consideration upon the demutualization or liquidation of the mutual insurance holding company.

(10) "Mutual insurance holding company" and "mutual non-life insurance holding company" both mean a domestic mutual holding company formed as a result of the conversion of a mutual insurer as defined in this Subpart pursuant to R.S. 22:231 et seq., and R.S. 22:691 et seq., in accordance with a plan of reorganization approved by the commissioner.

(11) "Mutual insurer" and "mutual non-life insurer" both mean for purposes of this Subpart a domestic mutual insurer subject to Subpart C of this Part, R.S. 22:111 et seq., that is authorized to transact any lines of insurance in this state, except the lines described in R.S. 22:47 (1), (2), and (9) but does not mean a domestic nonprofit mutual association as described in R.S. 22:124 nor an insurer organized pursuant to R.S. 23:1393 et seq.

(12) "Parent corporation" means a corporation, including a limited liability company, that is or has been organized for the purpose of acquiring, directly or indirectly, all of the common shares of a reorganized insurer.

(13) "Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a limited liability company, a limited liability partnership, a government or governmental agency, a state or political subdivision of a state, board, estate, trustee or fiduciary, or any other legal entity.

(14) "Plan of reorganization" means the plan of reorganization adopted by the reorganizing mutual in compliance with this Subpart.

(15) "Policy" means an individual or group policy of insurance issued, or deemed by the plan of reorganization to have been issued, by a mutual insurer or by a reorganized insurer. If a policy is a group policy, the individual certificates or other evidences of interests in the group policy shall not be treated as separate policies; however, in the case of a policy or contract that was issued to a trust or group established or deemed by the plan of reorganization to have been established by the mutual insurer or the reorganized insurer, the reorganizing mutual may provide in its plan of reorganization that each certificate or other evidence of interest is deemed to be a policy for the sole purpose of determining the rights, if any, of the holders of those certificates to receive consideration under the plan of reorganization.

(16) "Policyholder" means a person who, on the basis of the records and the organizational documents of the mutual insurer or reorganized insurer, is deemed to be a policyholder of such insurer.

(17) "Qualified voter" is a member of the reorganizing mutual that is entitled to vote on matters coming before corporate meetings of the reorganizing mutual pursuant to its articles of incorporation and bylaws.

(18) "Reorganized company" means either: (a) a reorganized insurer resulting from the reorganization of a mutual insurer under this Subpart; or (b) a reorganized insurance holding company.

(19) "Reorganized insurance holding company" means a former mutual insurance holding company reorganized as a stock insurance holding company, or a stock insurance holding company into which a mutual insurance holding company has been merged, pursuant to a plan of reorganization under this Subpart.

(20) "Reorganized insurer" means: (a) with respect to a conversion of a mutual insurer under this Subpart, the domestic stock insurer into which a mutual insurer is being or has been reorganized; or (b) with respect to the conversion of a mutual insurance holding company under this Subpart, any former mutual insurance company previously reorganized as a stock insurance company as part of a mutual insurance holding company reorganization under R.S. 22:231 et seq., and R.S. 22:695 et seq., or under the mutual insurance holding company laws of another state.

(21) "Reorganizing mutual" means a mutual insurer or mutual insurance holding company that is reorganizing pursuant to this Subpart.

Added by Acts 2009, No. 234, § 1. Amended by Acts 2010, No. 730, § 1, eff. June 29, 2010.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 237.3. Conversion of mutual insurers and mutual insurance holding companies authorized

A. A mutual insurer may, pursuant to R.S. 22:71 and 72 and the provisions of this Subpart, reorganize into a stock insurance company that may be or become a subsidiary of a parent corporation that is or has been formed for the purpose of acquiring, directly or indirectly, all of the common stock of such reorganized insurer.

B. A mutual insurance holding company may, pursuant to the provisions of this Subpart, reorganize into a stock insurance holding company.

Added by Acts 2009, No. 234, § 1.

§ 237.4. Plan of reorganization

A. A reorganizing mutual seeking to reorganize pursuant to the provisions of this Subpart shall submit a proposed plan of reorganization to the commissioner. The plan of reorganization shall include the following:

(1) A statement analyzing the benefits and risks attendant to the proposed reorganization, including the rationale for the reorganization.

(2) A statement indicating how the reorganization will protect the immediate and

long-term interests, and serve the best interests of policyholders.

(3) Copies of the articles of incorporation and bylaws of the reorganized company and any affiliate parent corporation, stockholding companies, and reorganized insurers.

(4) Information sufficient to demonstrate that the financial condition of any reorganized insurer will not be diminished upon reorganization.

(5) A description of any plans for the initial sale of stock of the reorganizing mutual or any parent corporation or affiliate stockholding company.

B. The plan of reorganization shall:

(1) Provide that all membership interests in the reorganizing mutual shall be extinguished as of the effective date.

(2) Require the distribution of consideration, in a fair and equitable manner, to all eligible members upon extinguishment of the membership interests.

(3) Specify the manner in which the aggregate value of the consideration shall be determined and the method by which the consideration shall be allocated among eligible members.

(4) Provide dividend protections for the reasonable dividend expectations, if any, of policyholders of any reorganized insurer, all as set forth in R.S. 22:237.5.

C. The plan of reorganization shall have been duly adopted by action of not less than two-thirds of the members of the entire board of directors of the reorganizing mutual.

D. A plan of reorganization filed with the commissioner pursuant to this Section shall be accompanied by the proposed forms of notice required by R.S. 22:237.6(C) and 237.7(C).

E. All information, documents, and copies thereof obtained by or disclosed to the commissioner, the Department of Insurance, or its designated representative in the course of an examination of a proposed plan of reorganization shall be treated in accordance with R.S. 22:706.

Added by Acts 2009, No. 234, § 1.

§ 237.5. Consideration and dividend protections

A. In effecting a conversion of a reorganizing mutual, each eligible member shall be entitled to consideration in an amount equal to his or its equitable share of the value of the reorganizing mutual as provided for in the plan of reorganization, as follows:

(1) The consideration to be distributed to eligible members may consist of cash, stock of the reorganized company or its parent corporation, subscription rights, premium credits, any combination of these forms of consideration, or other forms of consideration acceptable to the commissioner. The form or forms of

consideration to be distributed to an eligible member may differ according to the class or category of policy owned by the eligible member. The choice of the form or forms of consideration to be distributed to eligible members in accordance with the class or category of policy owned by such members may take into account such factors as the type of policy with respect to which the consideration is being distributed and the amount being distributed with respect to such policies, the country of residence, or tax status of the member or other appropriate factors; however, if the consideration to be distributed to an eligible member will be in a form other than common stock of a publicly traded company, the plan of reorganization shall include provisions for determining, in a reasonable manner, the value of the consideration by means of reference to the per share public market value of the registered common stock of the reorganized company or its parent corporation or another method acceptable to the commissioner, which provisions may, but are not required to, include an appraisal or valuation.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from a qualified investment banker that the provision of consideration upon the extinguishment of the membership interests pursuant to the plan of reorganization is fair to the eligible members, as a group, from a financial point of view.

B. The method of allocating consideration among eligible members shall be fair and equitable, as follows:

(1) The method shall provide for each eligible member to receive: (a) a fixed component of consideration or a variable component of consideration, or both; or (b) any other component of consideration acceptable to the commissioner. Components may reflect, based upon fair and equitable formulas, methods, and assumptions, factors such as (x) the ratio which the net premiums (gross premiums less return premiums and dividends paid) such eligible member has properly and timely paid to the insurer as a policyholder on insurance policies in effect during the three years immediately preceding the adoption date bears to the total net premiums received by the insurer from all eligible members as policyholders; or (y) estimated proportionate historical and prospective contributions to surplus of classes or groupings of policies and contracts to the aggregate component of consideration being distributed to eligible members, with each eligible member receiving a distribution in accordance with the type of policy owned by the eligible member; or (z) other factors the commissioner may approve.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from an actuary who is a member of the American Academy of Actuaries that the methodology and underlying assumptions for allocation of consideration among eligible members are reasonable and appropriate and the resulting allocation is fair and equitable.

C. At the option of the reorganizing mutual, any shares of the reorganized insurer or its parent corporation included in the eligible members' consideration may be placed on the effective date of the reorganization in a trust or other entity existing for the exclusive benefit of eligible members and established for the purpose of effecting the reorganization, such consideration or the proceeds of the sale of such consideration to be distributed to such eligible members by means of a process specified in the plan of reorganization and not to last more than twenty-one years after the effective date of the reorganization or until notification of the death of the eligible member or the death of the insured,

whichever occurs first.

D. (1) The plan of reorganization shall provide for the reasonable dividend expectations, if any, of policyholders of any reorganized insurer through the establishment, or in the case of a reorganizing mutual insurance holding company the continuation, of dividend protections, which may consist of a closed block or any other method acceptable to the commissioner. The sole purpose of any dividend protections shall be to provide for reasonable policyholder dividend expectations, if any.

(2) Any dividend protection provision may be limited to participating individual policies in force or deemed to be in force by the plan of reorganization on the effective date of the reorganization, or, in the case of a reorganized insurer in a mutual insurance holding company system, on the effective date of its reorganization as such, for which the insurer has or had an experience-based dividend scale due, paid or accrued by action of the board of directors of the insurer in the year in which the plan of reorganization is or was adopted; however, other categories of policies and benefits not described in this Paragraph may be included or excluded, subject to the approval of the commissioner.

(3) If dividend protections have been provided to policyholders of a reorganized insurer as part of a previous plan of reorganization, such dividend protections may be continued in effect without change in satisfaction of the requirements of this Section.

Added by Acts 2009, No. 234, § 1. Amended by Acts 2010, No. 730, § 1, eff. June 29, 2010.

§ 237.6. Approval by commissioner after public hearing

A. The commissioner shall hold a public hearing upon notice as set forth in this Section to hear evidence upon whether the plan of reorganization: (1) properly protects the interests of the policyholders as such and as members, (2) serves the best interests of policyholders and members, and (3) is fair and equitable to policyholders and members. The provisions of Subpart G of Part III of this Chapter, R.S. 22:691 et seq., shall not be applicable to any hearing held under this Subpart, and any such hearing shall be governed by the procedures set forth in this Subpart.

B. (1) Within thirty days after the closing of the administrative record after the public hearing as provided in this Section, the commissioner shall issue a final order or decision approving the plan if satisfied that each of the following conditions are met:

(a) The interests of the policyholders as such and as members are properly protected.

(b) The plan of reorganization serves the best interests of policyholders and members.

(c) The plan of reorganization is fair and equitable to policyholders and members.

(2) Any such final decision or order by the commissioner shall be subject to any modifications of the plan of reorganization the commissioner finds necessary for

the protection of the policyholders and members.

C. Subject to the review and appeal process under Subsection E of this Section, the commissioner's public hearing shall be the exclusive hearing with respect to the plan of reorganization. Not less than thirty days notice of such public hearing shall be provided by the reorganizing mutual to qualified voters and to such additional persons and in such manner as may be specified by the commissioner. The commissioner may promulgate procedures, rules, and regulations for the conduct of the public hearing.

D. The commissioner may retain at the reorganizing mutual's expense such attorneys, actuaries, accountants, and other experts as may be reasonably necessary to assist the commissioner in his examination of a proposed conversion, including any part of such examination that may occur, at the request of a reorganizing mutual, prior to a plan of reorganization having been filed with the commissioner pursuant to R.S. 22:237.4. Such experts shall prepare a projection of the amount of time and expenses necessary to complete the examination, and all work of these experts is subject to review. If the projected amount of time and expenses required to complete the examination appear excessive, the reorganizing mutual may petition the commissioner for appropriate relief, and the commissioner's decision shall be final.

E. (1) An aggrieved party may appeal the commissioner's final order to the Nineteenth Judicial District Court within thirty days of the order. The aggrieved party may also apply for a stay of the commissioner's order.

(2) The district court reviewing an order of the commissioner shall consider only the certified administrative record and the issues raised before the commissioner. The district court reviewing an order of the commissioner shall not modify or set aside the order unless the court finds: (a) error to the prejudice of the appellant's substantial rights arising from the commissioner's application of the law so grossly as necessarily to imply bad faith; (b) the commissioner's order or decision was procured by fraud; (c) the commissioner acted outside of the statutory authority of the Department of Insurance; or (d) the commissioner's action was arbitrary and capricious. Any appeal of the district court's review of the commissioner's order shall be taken within thirty days of the judgment of the district court; if no appeal is taken, the right to have an appellate court review or restrain action under the commissioner's order or decision shall be preempted and shall forever expire. Collateral attacks on an order of the commissioner are impermissible and shall be dismissed by the reviewing court.

(3) In any action challenging the validity of or arising out of any action taken or proposed to be taken under this Subpart, the reorganizing mutual or reorganized company shall be entitled at any stage of the proceedings before final judgment to petition the court to require the plaintiff or plaintiffs to give security for the reasonable costs, including attorney fees, which may be incurred by the reorganizing mutual or reorganized company, to which security the reorganizing mutual or reorganized company shall have recourse in such amount as the court having jurisdiction of such action shall determine upon termination of such action. The amount of security may thereafter from time to time be increased or decreased in the discretion of the court having jurisdiction of such action upon a showing that the security provided has or may become inadequate or excessive. If the court renders judgment in favor of the reorganizing mutual or reorganized

company, the court may in its discretion award attorney fees and costs to such prevailing party.

F. The provisions of this Section shall apply to all actions challenging the validity of or arising out of any action taken or proposed to be taken under this Subpart and R.S. 22:71 and 72.

Added by Acts 2009, No. 234, § 1.

§ 237.7. Approval by qualified voters

A. The plan of reorganization shall be approved at a meeting convened for that purpose by a vote of not less than two-thirds of the qualified voters of the reorganizing mutual entitled to vote on matters and present or represented by special ballot or special proxy.

B. The meeting of qualified voters to consider the plan of reorganization shall occur after the public hearing before the commissioner, and the closing of the administrative record after the public hearing shall not occur until such time as it includes certification by the reorganizing mutual to the commissioner of the vote on the plan of reorganization by the qualified voters of the reorganizing mutual.

C. All qualified voters shall be given notice of their opportunity to vote on the plan of reorganization, which notice shall include a copy of the plan of reorganization or a summary thereof and which shall be in a form that the commissioner has determined is adequate and may be provided to qualified voters. The notice may be combined with notice of the public hearing. The notice shall be mailed, or provided by some other method or methods as may be approved by the commissioner, not less than thirty days before the date of the meeting of qualified voters to vote on the plan of reorganization. If the reorganizing mutual complies substantially and in good faith with the notice requirements of this Section, the failure of any person to actually receive any required notice will not impair the validity of any action taken under this Subpart.

D. A quorum for the meeting of qualified voters to consider the plan of reorganization shall consist of the qualified voters present or represented by special ballot or special proxy.

E. Voting, ballot, and proxy submission may take place electronically or telephonically consistent with the requirements of the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq.

Added by Acts 2009, No. 234, § 1.

§ 237.8. Limitations on acquisition of beneficial ownership

A. Except as otherwise specifically provided in the plan of reorganization, prior to and for a period of five years following the effective date of the reorganization, no person or persons acting in concert, other than the reorganized company or any employee benefit plans or trusts sponsored by the reorganized company or its corporate affiliates, shall directly or indirectly offer to acquire or acquire in any manner the beneficial ownership of five percent or more of any class of a voting security of the reorganized company or any person that owns or

controls a majority or all of the voting securities of the reorganized company without the prior approval by the commissioner of an application for acquisition filed by that person with the commissioner.

B. The commissioner shall not approve an application for acquisition unless he finds each of the following:

(1) The acquisition would not frustrate the plan of reorganization as approved by the qualified voters and the commissioner.

(2) The board of directors of the reorganized company or its parent corporation, as applicable, has approved the acquisition, or extraordinary circumstances not contemplated in the plan of reorganization have arisen that would warrant their approval of the acquisition.

(3) The acquisition would be in the best interest of the reorganized company and policyholders of the reorganized insurer or insurers. In determining whether an acquisition would be in the best interest of the reorganized company and policyholders of the reorganized insurer or insurers, the commissioner may consider such factors as he deems relevant, which may but are not required to include any or all of the following: (a) the possible effects on shareholders, employers, suppliers, creditors, and customers of the reorganized company and its affiliates; (b) possible effects on the economy of the communities in which the reorganized company is located, and on that of this state; and (c) company and policyholders of the reorganized insurer or insurers, including but not limited to the possibility that those interests may be best served by the continued independence of the reorganized company.

C. No security that is the subject of any agreement or arrangement regarding acquisition or that is acquired or to be acquired in contravention of this Section or of an order of the commissioner may be voted at any shareholders' meeting, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; however, no action taken at a meeting shall be invalidated by the voting of those securities unless the action would materially affect control of the reorganized insurer or a person that owns or controls a majority or all of the voting securities of the reorganized insurer or unless the courts of this state have so ordered.

Added by Acts 2009, No. 234, § 1.

§ 237.9. Limitations on compensation of directors, officers, agents, and employees

Except as set forth in the plan of reorganization approved by the qualified voters and the commissioner or in a stock-based compensation program or arrangement using options or other securities previously registered with the commissioner pursuant to R.S. 22:88 or any successor statute, no director, officer, agent, or employee of the reorganizing mutual shall receive any fee, commission, or other valuable consideration, other than his regular salary and compensation, that is contingent upon the plan of reorganization becoming approved or effective or is based upon aiding, promoting, or assisting in the approval or effectuation of the plan of reorganization. This Section shall not prohibit compensation programs or arrangements including programs and

arrangements involving the use of the stock of the reorganized company or its parent corporation, which are to become effective simultaneously with the plan of reorganization or thereafter, provided such programs and arrangements are contained in the plan of reorganization approved by the qualified voters and the commissioner or in a program or arrangement using options or other securities previously registered with the commissioner pursuant to R.S. 22:88 or any successor statute. This Section shall not be deemed to prohibit such a program or arrangement from being adopted after the effective date of a reorganization.

Added by Acts 2009, No. 234, § 1.

§ 237.10. Filing of certificate of compliance; effective date of reorganization

A. On or prior to the effective date of the reorganization, the reorganizing mutual shall file with the commissioner a certificate stating that:

(1) All of the conditions set forth in the plan of reorganization, including a final order by the commissioner granting permission to reorganize in accordance with the plan of reorganization pursuant to R.S. 22:237.6 and approval by qualified voters pursuant to R.S. 22:237.7, have been satisfied.

(2) The board of directors of the reorganizing mutual has not abandoned the plan of reorganization.

B. Notwithstanding the provisions of R.S. 12:23, the articles of incorporation of the reorganizing mutual shall be approved and recorded in accordance with the provisions of R.S. 22:63 and 64.

C. The reorganization shall be effective upon the date and hour certified by the commissioner, which shall be the later of: (1) the date and hour when the articles of incorporation were filed for record in the office of the proper recorder of mortgages; or (2) such other date and time specified in the articles of incorporation as the date and hour when the reorganization shall be effective, which shall not be later than the tenth day after the date the articles of incorporation are recorded.

Added by Acts 2009, No. 234, § 1. Amended by Acts 2010, No. 730, § 1, eff. June 29, 2010.

§ 237.11. Effect of reorganization

A. With respect to the conversion of a mutual insurer, upon the effective date, the mutual insurer shall immediately become a stock insurer, all membership interests shall be extinguished, and the reorganized insurer or its parent corporation will act in good faith to convey consideration to eligible members pursuant to the plan of reorganization. The reorganized insurer shall be a continuation of the mutual insurer, and the reorganization in no way shall annul, modify, or change any of the mutual insurer's existing suits, rights, contracts, or liabilities, except as provided in the plan of reorganization. After reorganization, the reorganized insurer shall exercise all the rights and powers and perform all the duties conferred or imposed by law upon insurers writing the classes of insurance written by it, and shall be vested in all the rights, franchises, and interests of the mutual insurer in and to every species of property without any deed or transfer, and the reorganized insurer shall succeed

to all the obligations and liabilities of the mutual insurer, and retain all rights and contracts existing prior to conversion, except as provided in the plan of reorganization.

B. With respect to the conversion of a mutual insurance holding company, upon the effective date, the membership interests of the members of the mutual insurance holding company shall be extinguished, and the reorganized company shall act in good faith to convey consideration to eligible members pursuant to the plan of reorganization. Each reorganized insurer within the mutual insurance holding company system will continue its corporate existence as a stock insurer within a stock insurance holding company system, and the reorganization shall in no way annul, modify, or change any of such reorganized insurer's existing suits, rights, contracts, or liabilities, except as provided in the plan of reorganization.

Added by Acts 2009, No. 234, § 1.

§ 237.12. Abandoning or amending plan of reorganization

The reorganizing mutual may, by action of not less than two-thirds of its board of directors, abandon or amend the plan of reorganization at any time before the effective date. No amendment made after the public hearing required by R.S. 22:237.6 shall change the plan of reorganization in a manner which the commissioner determines is materially disadvantageous to policyholders or members unless a further public hearing is held on the plan as amended.

Added by Acts 2009, No. 234, § 1.

§ 237.13. Directors and officers of the reorganized company

The directors and officers of the reorganizing mutual, unless otherwise specified in the plan of reorganization, shall serve as the directors and officers of the reorganized company until new directors and officers are duly elected pursuant to the articles of incorporation and bylaws of the reorganized company.

Added by Acts 2009, No. 234, § 1.

SUBPART I. HEALTH MAINTENANCE ORGANIZATIONS

§ 241. Short title

This Subpart may be cited as the Health Maintenance Organization Act.

Renumbered from R.S. 22:2001 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1.

§ 242. Definitions

As used in this Subpart:

(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. The term shall also include coverage for low protein food products as provided in R.S. 22:246.

(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. The term shall also include an annual Pap test for cervical cancer and minimum mammography examination as defined in R.S. 22:1028 and coverage for low protein food products as provided in R.S. 22:246.

(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. 22:73, 96, 691 through 713, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., R.S. 22:1022 and 1023, Part II of Chapter 7 of this Title, R.S. 22:1921 through 1929, and Chapter 9 of this Title, R.S. 22:2001 et seq. 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 R.S. 22:34, 35, 851-870, 872-883, 885-889, 901, 902, 944, 945, 972-983, 985-990, 992-1015, 1021-1048, 1091-1097, 1111, 1156, 1261-1270, 1281-1283, 1285-1288, 1290-1293, 1295-

1297, 1331, 1333-1335, 1441, 1555, 1811, 1821-1823, and 1891-1894.

Renumbered from R.S. 22:2002 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by 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; Acts 2009, No. 503, § 1; Acts 2012, No. 271, § 1.

§ 243. 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 and municipal addresses or locations, which shall not be a post office box only, 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, if any.

(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 Subpart.

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 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 Paragraph (4) of this Subsection 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 Subpart 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 Paragraphs (1) and (2) of this Subsection 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 Subpart. If a conflict exists between the provisions of this Subpart and said provisions of Title 12, the provisions of this Subpart shall govern.

Renumbered from R.S. 22:2003 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1999, No. 342, § 6; Acts 2006, No. 342, § 1, eff. June 13, 2006; Acts 2009, No. 503, § 1; Acts 2010, No. 84, § 1.

§ 244. 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 Subpart.

B. Every health maintenance organization holding a certificate of authority issued by the commissioner prior to the effective date of this Subpart, may continue to operate as a health maintenance organization under this Subpart, 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 Subpart. Health maintenance organizations organized prior to the effective date of this Subpart 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. 22:242(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 Subpart 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. 22:257.

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 Subpart.

(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. 22:267.

(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. 22:250(B).

D. (1) An applicant, or a health maintenance organization holding a certificate of authority granted hereunder, unless otherwise provided for in this Subpart, 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.

Renumbered from R.S. 22:2004 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by 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.

§ 245. Hearing impaired interpreter expenses; requirement

As a requirement for authorization to do business in this state pursuant to R.S. 22:244, 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.

Renumbered from R.S. 22:2004.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1313, § 1; Acts 1997, No. 1324, § 1.

§ 246. Inherited metabolic diseases; coverage for food products

A. Every health maintenance organization granted a certificate of authority under this Subpart and every insurer licensed under the provisions of Subpart C of Part I of Chapter 2 of this Title that engages in health maintenance organization activities authorized and regulated pursuant to this Subpart 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. Repealed by Acts 2009, No. 503, § 2.

Renumbered from R.S. 22:2004.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 829, § 1.

§ 247. Reimbursement for chiropractic services

Notwithstanding any provision of any policy or contract of insurance or health benefits issued by a health maintenance organization, 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.

Renumbered from R.S. 22:2004.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2005, No. 395, § 1. Amended by Acts 2009, No. 503, § 1.

§ 248. 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. 22:254.

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 Subpart shall remain in effect until revoked or suspended by the commissioner.

Renumbered from R.S. 22:2005 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1.

§ 249. Authority of health maintenance organizations

Subject to the provisions of R.S. 22:260(E) and regulations adopted and approved by the commissioner, the authority of a health maintenance organization includes but is not limited to the following:

(1) The authority 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 authority 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 authority to furnish health care services through providers which are under contract with or employed by the health maintenance organization.

(4) The authority to contract with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration.

(5) The authority 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 authority to offer other health care services in addition to basic health care services.

(7) The authority 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 authority 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.

Renumbered from R.S. 22:2006 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1999, No. 878, § 1, eff. July 2, 1999; Acts 2009, No. 503, § 1.

§ 250. 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.

Renumbered from R.S. 22:2007 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1986, No. 1065, § 1. Amended by Acts 2009, No. 503, § 1.

§ 251. 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 Subpart. Such health maintenance organization 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, 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 five 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. If books and records 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.

Renumbered from R.S. 22:2007.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1231, § 1, eff. Sept. 1, 1995. Amended by Acts 2010, No. 84, § 1.

§ 252. 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. 22:269.

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. 22:571.

(2) Management and discussion reports as required by R.S. 22:571 and the National Association of Insurance Commissioners Annual Statement Instructions Handbook.

(3) A CPA-audited report as required by R.S. 22:673 and any applicable regulation issued by the Department of Insurance.

(4) Holding Company Act filings as required under Subpart G of Part III of this Chapter, R.S. 22:691 et seq.

Renumbered from R.S. 22:2008 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1995, No. 1231, § 1, eff. Sept. 1, 1995; Acts 2009, No. 503, § 1.

§ 253. Investments

With the exception of investments made in accordance with R.S. 22:249(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.

Renumbered from R.S. 22:2009 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1.

§ 254. 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, capital and surplus in the amount of three million dollars.

D. (1) In lieu of the one million dollar aggregate deposit or deposits provided by Subsection A of this Section, 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 Subpart; 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. 22:257.

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 Subpart, 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.

Renumbered from R.S. 22:2010 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1995, No. 1231, § 1, eff. Sept. 1, 1995; Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003; Acts 2009, No. 503, § 1; Acts 2012, No. 54, § 1.

§ 255. Regulation of producers

The commissioner may, after notice and public hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of producers. A producer means a person licensed as a life and health insurance producer 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.

Renumbered from R.S. 22:2011 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 256. 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 five years.

B. The commissioner or a member of his staff shall conduct all examinations in accordance with R.S. 22:1981 through 1995.

Renumbered from R.S. 22:2012 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1995, No. 1231, § 1, eff. Sept. 1, 1995; Acts 2009, No. 503, § 1.

§ 257. 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 Subpart 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. 22:244, unless the health maintenance organization filed with the commissioner those modifications as required by R.S. 22:244(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 Subpart.

(7) The health maintenance organization has failed to file or to timely file any of the financial statements as required under this Subpart.

(8) The health maintenance organization has failed to comply with any requirements of any provision found under this Subpart.

(9) The health maintenance organization has failed to maintain a statutory deposit as required pursuant to R.S. 22:254.

B. A certificate of authority shall be suspended or revoked only after compliance with the requirements of R.S. 22:259 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.

Renumbered from R.S. 22:2013 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Renumbered from R.S. 22: by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1995, No. 1231, § 1, eff. Sept. 1, 1995; Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003.

§ 258. 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 Subpart. Such rules and regulations shall be subject to rulemaking and review in accordance with the Administrative Procedure Act.

Renumbered from R.S. 22:2014 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1.

§ 259. Administrative procedures

When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of an application for a certificate of authority exist, in accordance with R.S. 49:961, he shall issue an order denying, suspending, or revoking the application and shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension, or revocation. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:2015 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 2009, No. 317, § 1.

§ 260. Statutory construction; relationship to other laws

A. Except as otherwise provided in this Subpart and in R.S. 22:1037, provisions of the insurance law and provisions of Subpart C of this Part, R.S. 22:111 et seq., shall not be applicable to any health maintenance organization granted a certificate of authority under this Subpart. This provision shall not apply to an insurer or an entity licensed under the provisions of Subpart C of this Part except with respect to its health maintenance organization activities authorized and regulated pursuant to this Subpart.

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 Subpart 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.

Renumbered from R.S. 22:2016 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 2003, No. 190, § 1; Acts 2009, No. 503, § 1.

§ 261. Repealed by Acts 2009, No. 503, § 2

§ 262. 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 Subpart.

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. Every health maintenance organization which has been licensed under this Subpart 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.

Renumbered from R.S. 22:2017 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1997, No. 238, § 1, eff. June 16, 1997; Acts 2009, No. 503, § 1.

§ 263. 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. 22:267. 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.

Renumbered from R.S. 22:2018 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1995, No. 1159, § 1; Acts 1997, No. 238, § 1, eff. June 16, 1997; Acts 1997, No. 897, § 1.

§ 264. 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. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:2019 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 2009, No. 317, § 1.

§ 265. 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 Subpart 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.

Renumbered from R.S. 22:2020 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1.

§ 266. Medical necessity review

Every health maintenance organization shall assure full compliance with Subpart F of Part III of Chapter 4 of this Title, R.S. 22:1121 et seq., 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.

Renumbered from R.S. 22:2021 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1997, No. 238, § 1, eff. June 16, 1997; Acts 1997, No. 1324, § 1; Acts 1999, No. 401, § 1, eff. Jan. 1, 2000; Acts 2009, No. 503, § 1.

§ 267. 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, R.S. 49:950 et seq., 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.

Renumbered from R.S. 22:2022 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 1997, No. 238, § 1, eff. June 16, 1997; Acts 2009, No. 317, § 1.

§ 268. 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.

Renumbered from R.S. 22:2023 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1.

§ 269. Fees

A. The following fees shall be collected in advance by the secretary of state for health maintenance organization:

(1)<COL>For filing a charter, other documents, and amendments thereto, per page<COL>$ 2.50

(2)<COL>For certified copies of any document, per page<COL>$ 2.00

B. The following fees and licenses shall be collected in advance by the commissioner of insurance for health maintenance organizations:

(1)<COL>Certificates of authority<COL>$ 500.00

(2)<COL>Repealed by Acts 2012, No. 206, § 1.<COL>

(3)<COL>(a)<COL>For filing annual statement<COL>250.00

<COL>(b)<COL>Penalty for unauthorized late filing<COL>1,000.00

(4)<COL>Initial examination of health maintenance organization companies<COL>1,000.00

(5)<COL>Repealed by Acts 2012, No. 206, § 1.<COL>

(6), (7) Repealed by Acts 1996, 1st Ex.Sess., No. 71, § 2, eff. May 10, 1996.<COL>

(8)<COL>The commissioner may assess additional regulatory fees due to costs incurred by the Louisiana Department of Insurance<COL>

Renumbered from R.S. 22:2024 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 2001, No. 161, § 1.

§ 270. 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. 22:244(B), shall pay an annual license tax 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. 22:842 and R.S. 22:844.

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. 22:845. 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. 22:843.

D. The tax credit provided pursuant to R.S. 22:832 shall apply the same for health maintenance organizations as for insurance companies.

E. The provisions of R.S. 22:846 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. 22:795 regarding the maintenance of books and records and the disposition of collections.

Renumbered from R.S. 22:2025 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 1065, § 1. Amended by Acts 2009, No. 503, § 1.

§ 271. 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. 22:1969.

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.

Renumbered from R.S. 22:2026 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 695, § 1, eff. Jan. 1, 1990. Amended by Acts 1997, No. 238, § 1, eff. June 16, 1997.

§ 272. 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 Subpart 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 Subpart 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. (1) The notice provisions of Subsections A and B of this Section shall not apply to cancellations due to nonpayment on a timely basis of the prepaid charges.

(2) Every health maintenance organization issuing a contract for health care services shall include in such contract a provision providing the subscriber or enrollee a grace period of thirty days from the date the prepaid charge was due. If the prepaid charge is paid during the grace period, then coverage shall remain in effect pursuant to the provisions of the contract.

(3) Whenever a health maintenance organization does not receive a prepaid charge payment fifteen days prior to the end of the grace period, the health maintenance organization shall mail, by first class mail, a notice to the subscriber or enrollee. The notice shall state that if the prepaid charge has not been paid by the end of the grace period, the contract will lapse as provided by the provisions of the contract. The notice shall also state that the contract will be reinstated with no penalties whatsoever to the subscriber or enrollee if the full payment is received within the period allowed for reinstatement.

D. (1)(a) Every health maintenance organization authorized under this Subpart 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 Subpart 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 limited benefit health insurance policies or contracts.

F. Every health maintenance organization authorized under this Subpart shall also be subject to the requirements of Subpart B of Part II of Chapter 6 of this Title, R.S. 22:1831 et seq.

Renumbered from R.S. 22:2027 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 538, § 1. Amended by Acts 1995, No. 637, § 1; Acts 1997, No. 1313, § 1; Acts 1997, No. 1341, § 1; Acts 1999, No. 1017, § 1, eff. July 9, 1999; Acts 2006, No. 396, § 1, eff. Jan. 1, 2007; Acts 2009, No. 503, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

SUBPART J. FRATERNAL BENEFIT SOCIETIES

§ 281. 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. 22:317(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 Subpart.

Renumbered from R.S. 22:541 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 282. 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.

Renumbered from R.S. 22:542 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 283. 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.

Renumbered from R.S. 22:543 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 284. General definitions

As used in this Subpart, 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. 22:296, as that agreement is described in R.S. 22:299(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.

Renumbered from R.S. 22:544 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 285. 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. 22:296.

(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.

Renumbered from R.S. 22:545 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 286. 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.

Renumbered from R.S. 22:546 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 287. 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.

Renumbered from R.S. 22:547 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 288. 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.

Renumbered from R.S. 22:548 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 289. 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.

Renumbered from R.S. 22:549 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 290. Organization

A domestic society organized pursuant to this Subpart 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 Subpart.

(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 Subpart 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. 22:64. 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 Subpart. 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 shall not be required to reincorporate. Any voluntary fraternal benefit association may incorporate hereunder.

Renumbered from R.S. 22:550 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988. Amended by Acts 2009, No. 503, § 1.

§ 291. 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.

Renumbered from R.S. 22:551 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 292. 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. 22:285(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.

Renumbered from R.S. 22:552 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 293. 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 Subpart, unless the

reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or 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. 22:294.

Renumbered from R.S. 22:553 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 294. 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.

Renumbered from R.S. 22:554 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 295. 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.

Renumbered from R.S. 22:555 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 296. 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 Subpart.

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.

Renumbered from R.S. 22:556 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 297. 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.

Renumbered from R.S. 22:557 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 298. 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.

Renumbered from R.S. 22:558 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 299. 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 Subpart shall meet the standard contract provision requirements not inconsistent with the Subpart 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.

Renumbered from R.S. 22:559 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 300. Nonforfeiture benefits, cash surrender values, certificate loans, and other options

A. For certificates issued prior to one year after the effective date of this Subpart, 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 Subpart.

B. For certificates issued on or after one year from the effective date of this Subpart 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.

Renumbered from R.S. 22:560 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 301. 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.

Renumbered from R.S. 22:561 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 302. 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. 22:299(B) and (D) shall not apply.

Renumbered from R.S. 22:562 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 303. Exemptions

Except as herein provided, societies shall be governed by this Subpart 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 Subpart.

Renumbered from R.S. 22:563 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 304. Taxation

Every society organized or licensed under this Subpart 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.

Renumbered from R.S. 22:564 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 305. Valuation

A. Standards of valuation for certificates issued prior to one year after the effective date of this Subpart shall be those provided by the laws applicable immediately prior to the effective date of this Subpart.

B. The minimum standards of valuation for certificates issued on or after one year from the effective date of this Subpart 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.

Renumbered from R.S. 22:565 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 306. 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. 22:305. 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.

Renumbered from R.S. 22:566 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 307. 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 Subpart. 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 Subpart.

Renumbered from R.S. 22:567 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 308. 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.

Renumbered from R.S. 22:568 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 309. 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 Subpart 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. 22:314.

(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 Subpart.

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.

Renumbered from R.S. 22:569 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 310. 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 Subpart.

(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 at a hearing conducted in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq., 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 R.S. 22:73 and 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq.

B. Whenever a receiver is to be appointed for a domestic society, the commissioner of insurance shall be appointed as the receiver.

C. The provisions of this Section relating to a hearing and any action by the commissioner of insurance under R.S. 22:73 and 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq., shall be applicable to a society which shall voluntarily determine to discontinue business.

Renumbered from R.S. 22:570 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 311. 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 Subpart.

(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.

Renumbered from R.S. 22:571 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 312. 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.

Renumbered from R.S. 22:572 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 313. 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 IV of Chapter 7 of this Title, R.S. 22:1961 et seq., 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.

Renumbered from R.S. 22:574 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988. Amended by Acts 2009, No. 503, § 1.

§ 314. 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.

Renumbered from R.S. 22:575 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988. Amended by Acts 1999, No. 395, § 4.

§ 315. Review

All decisions and findings of the commissioner of insurance made under the provisions of this Subpart shall be subject to review in any court of competent jurisdiction of this state.

Renumbered from R.S. 22:576 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 316. 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 Subpart 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 Subpart for which a penalty is not otherwise prescribed, shall upon conviction be subject to a fine not exceeding two hundred dollars.

Renumbered from R.S. 22:577 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

§ 317. Exemption of certain societies

A. Nothing contained in this Subpart 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 Subpart, but shall comply with all requirements thereof.

C. No society which, by the provisions of this Section, is exempt from the requirements of this Subpart, 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 Subpart, 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 Subpart.

F. Societies exempted under the provisions of this Section shall also be exempt from all other provisions of the insurance laws of this state.

Renumbered from R.S. 22:578 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1987, No. 470, § 1, eff. Jan. 1, 1988.

SUBPART J-1. HEALTH CARE SHARING MINISTRIES

§ 318. Health care sharing ministry; definitions

As used in this Subpart, "health care sharing ministry" means a faith-based, nonprofit, tax-exempt organization that does each of the following:

(1) Limits its participants to those who are of a similar faith and acts as a facilitator between participants who have financial or medical needs and those

participants with the ability to provide financial or medical assistance in accordance with criteria established by the ministry.

(2) Provides amounts that participants may contribute without assumption of risk or promise to pay by the participants or by the ministry.

(3) Provides a written monthly statement to all participants listing the total dollar amount of qualified financial or medical needs submitted to the ministry and the dollar amount actually published or assigned to the participants for their contribution.

(4) Provides a written disclaimer on or with all applications and guideline materials distributed by or on behalf of the ministry that reads, in substance: "Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses."

Added by Acts 2014, No. 20, § 1.

§ 319. Exemption from provisions of the Insurance Code

Health care sharing ministries shall be exempt from all provisions of the insurance laws of this state unless the ministries are expressly provided for in such provisions or unless the provision is specifically made applicable by this Subpart.

Added by Acts 2014, No. 20, § 1.

§§ 320 to 330. Reserved for future legislation

SUBPART K. FOREIGN AND ALIEN INSURERS

§ 331. Foreign or alien insurers may be admitted

A. 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 Subpart, 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 nonprofit funeral insurance, and life, health and accident insurers on the cooperative or assessment plan, provided insurers admitted to transact the kinds of business provided in Subparts D and E of this Part, R.S. 22:131 et seq. and R.S. 22:141 et seq., shall meet the requirements for life insurers under R.S. 22:81 through 95 and Subpart C of this Part, R.S. 22:111 et seq.

B. 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.

C. (1) The commissioner of insurance may issue a certificate of authority, as provided in R.S. 22:336, admitting a foreign insurer to transact the business of health and accident insurance as defined in R.S. 22:47.

(2) The commissioner may waive those provisions of this Title necessary to admit a foreign insurer to transact the business of health and accident insurance as defined in R.S. 22:47 within the state.

(3) The commissioner shall not waive any provision of this Title unrelated to the disparate treatment of domestic and foreign insurers with respect to licensure and solvency requirements.

Renumbered from R.S. 22:981 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1; Acts 2015, No. 224, § 1.

§ 332. 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. 22:335.

(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 bylaws, and, if a fraternal society, a copy of its constitution, certified by its proper officers.

(5) Repealed by Acts 2010, No. 105, § 1.

(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. 22:335 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) of this Section 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.

Renumbered from R.S. 22:982 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2003, No. 130, § 1; Acts 2004, No. 377, § 1; Acts 2009, No. 503, § 1.

§ 333. Conditions of issuance of certificate of authority

A. After the requirements of R.S. 22:332 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 II of Chapter 3 of this Title, R.S. 22:801 et seq.

C. Before issuance of the certificate of authority to an alien insurer, such insurer shall make a deposit as required by Part II of Chapter 3 of this Title 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. Such 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.

(2) Two hundred thousand dollars.

(a) 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.

(b) 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 Subpart 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. 22:1269, 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.

Renumbered from R.S. 22:983 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1.

§ 334. 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.

Renumbered from R.S. 22:984 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 335. 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 registered or certified 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.

Renumbered from R.S. 22:985 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1999, No. 395, § 4; Acts 2012, No. 544, § 3.

§ 336. 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.

Renumbered from R.S. 22:986 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 337. 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 Subpart;

(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 Subpart;

(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 to maintain licensure as producers 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 in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

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.

Renumbered from R.S. 22:987 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 338. 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 Subpart 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. 22:333 are complied with.

Renumbered from R.S. 22:988 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 339. 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.

Renumbered from R.S. 22:989 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 391, § 1.

§ 340. 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 R.S. 22:73 and 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq., 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.

Renumbered from R.S. 22:990 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 1960, No. 391, § 1; Acts 2009, No. 503, § 1.

§ 340.1. Procedure following election or appointment of new officers or directors

A. Every foreign or alien insurer authorized to transact business in this state shall provide to the commissioner of insurance biographical information for all elected or appointed directors no more than sixty days from the effective date of the election or appointment.

B. Every foreign or alien insurer authorized to transact business in this state shall provide to the commissioner of insurance biographical information for all elected or appointed senior officers no more than sixty days from the effective date of the election or appointment.

C. For the purposes of this Section, "senior officers" shall mean president, secretary, chief executive officer, chief financial officer, actuary, controller, or any other person who performs the duties generally associated with those positions.

D. In addition to the biographical information required by this Section, the notice of election or appointment of an officer or director shall include the full name of the insurer for which the individual is serving as an officer or director, his position with each company, the effective date of his election or appointment to the position, and, if the individual is replacing another person in the named position, the full name of the person who previously held the position.

Renumbered from R.S. 22:990.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 11, § 1.

§ 341. 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 the insurer's domiciliary state or country 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 financial institution 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.

Renumbered from R.S. 22:991 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 357, § 1.

§ 342. 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.

Renumbered from R.S. 22:1580 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1976, No. 218, § 1, eff. Jan. 1, 1977.

§ 343. 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 thirty-first 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. 22:342, 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. 22:342, shall be eligible to participate upon certification. Such returns must be made by the said companies within sixty days after December thirty-first 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. 22:342, shall file a verified statement as required by the governing authority of the parish on or before October first 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. 22:342, 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. 22:342, 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 first 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.

Renumbered from R.S. 22:1581 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1958, No. 417, § 1; Acts 1976, No. 218, § 2, eff. Jan. 1, 1977.

§ 344. 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 thirty-first of each year.

Renumbered from R.S. 22:1582 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1976, No. 218, § 2, eff. Jan. 1, 1977.

§ 345. Tax on premiums

A foreign and alien insurer, other than a life insurer, shall, within sixty days

after December thirty-first 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. 22:343. If, however, the verified statement required of the insurer in R.S. 22:343 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.

Renumbered from R.S. 22:1583 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1958, No. 418, § 1; Acts 1984, No. 229, § 1.

§ 346. Investigation and collection by commissioner of insurance

If a company fails to keep the accurate accounts required in R.S. 22:344 or if the returns required in R.S. 22:343 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.

Renumbered from R.S. 22:1584 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1976, No. 218, § 2, eff. Jan. 1, 1977.

§ 347. Disposition of tax money

A. Monies collected under R.S. 22:342 through 349, 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)(a) 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.

(b) For the state fire marshal, an amount necessary to satisfy the requirements of R.S. 23:1036, relative to the purchase of workers' compensation insurance for volunteer firefighters.

(2)(a) 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.

(b) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge for allocation to Delgado Community College, 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. 22:343 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 Louisiana State University and Agricultural and Mechanical College Agriculture Center, Department of Agricultural Economics and Agribusiness, under the latest federal-state cooperative program for local population estimates. Such determination shall be submitted by the Louisiana State University and Agricultural and Mechanical College Agriculture Center, Department of Agricultural Economics and Agribusiness, 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 R.S. 22:342 through 349 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 these 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 this Section.

(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 R.S. 22:342 through 349 collected pursuant to R.S. 22:345. 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.

F. Repealed by Acts 2001, No. 189, § 3, eff. July 1, 2002.

Renumbered from R.S. 22:1585 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2007, No. 349, § 1; Acts 2009, No. 304, § 1, eff. July 1, 2009; Acts 2009, No. 503, § 1; Acts 2012, No. 555, § 1, eff. July 1, 2012.

§ 348. Penalties

Any foreign or alien insurer, other than life, which violates any provision of R.S. 22:342 through 349 shall, for each offense, be fined five hundred dollars.

Renumbered from R.S. 22:1586 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1958, No. 419, § 1.

§ 349. 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. 22:342 through 348 as well as all other conditions which may be now or hereafter imposed by law.

Renumbered from R.S. 22:1587 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1976, No. 218, § 2, eff. Jan. 1, 1977.

SUBPART L. VEHICLE MECHANICAL BREAKDOWN INSURERS

§ 361. Definitions

As used in this Subpart:

(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, company, insurer, association, organization, reciprocal or inter-insurance exchange, partnership, business, trust, limited liability company, or corporation which provides vehicle mechanical breakdown insurance in this state.

(5) "Reinsurer" means a person licensed under this Subpart 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) "Road hazard" shall include but not be limited to potholes, rocks, curbs, wood debris, other debris, nails, screws, bolts, metal parts, or glass; however, "road hazard" shall not include any damage caused by collision with another vehicle, vandalism, or other causes usually covered under the comprehensive or collision coverages provided by an automobile physical damage policy.

(8) "Vehicle component coverage contracts" means a contract which provides the owner or purchaser of a motor vehicle with one or more of the following coverages:

(a) "Paintless dent repair contract" means a contract which provides for the repair of or promises to pay for all or part of the cost to repair or remove dents, dings, or creases from the exterior of the motor vehicle utilizing the paintless dent repair process, provided that a paintless dent repair contract shall not cover sanding, bonding, painting, or the replacement of body panels.

(b) "Tire and wheel contract" means a contract which promises to pay for all or part of the cost to repair or replace tires and wheels which are damaged due to contact with a road hazard.

(c) "Windshield contract" means a contract which promises to pay for all or part of the cost of the repair or of the replacement of windshield or window glass on a motor vehicle when the damage to the glass is caused by contact with a road hazard.

(9) "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 or the expense or portion thereof for the mechanical breakdown or mechanical failure of a motor vehicle and may include 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.

(10) "Vehicle mechanical breakdown insurer" means any person or organization, whether domestic, foreign, or alien, issuing or attempting to issue vehicle mechanical breakdown policies or vehicle component coverage contracts as defined herein.

Renumbered from R.S. 22:1800 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1; Acts 2010, No. 194, § 1, eff. June 9, 2010.

§ 362. 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 first of each year and which shall be paid no later than March fifteenth 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.

C. Every licensee shall notify the commissioner within sixty days of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a license in this state. Material changes shall include but are not limited to the following:

(1) Changes in officers or directors.

(2) Changes in ownership.

(3) A change in the articles of incorporation.

(4) A merger.

(5) An addition or change of a trade name or "d/b/a".

(6) Cessation of business in Louisiana.

Renumbered from R.S. 22:1801 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 1986, No. 848, § 1; Acts 2014, No. 80, § 1.

§ 363. Exceptions

Nothing in this Subpart shall have any effect upon the giving of the customary manufacturer's warranty, or guarantee; nor shall this Subpart apply to or affect the giving or selling of performance warranties or guarantees by sellers of motor vehicles. Nothing in this Subpart 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.

Renumbered from R.S. 22:1802 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 1987, No. 710, § 1.

§ 364. Qualifications

A. The commissioner shall not license a vehicle mechanical breakdown insurer unless all of the following conditions are met:

(1) Applicant shall be solvent.

(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. 22:365, and

(4) Applicant shall be in compliance with and continue to be in compliance with all applicable laws.

B. The requirement for licensure shall not apply to tire and wheel coverage sold as a part of a service package in concert with the sale of one or more tires or one or more wheels.

Renumbered from R.S. 22:1803 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 2009, No. 503, § 1; Acts 2010, No. 194, § 1, eff. June 9, 2010.

§ 365. 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 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 issued by a surety insurer authorized 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; however, any interest earned on such securities shall be the property of the vehicle mechanical breakdown insurer.

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 vehicle mechanical breakdown 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.

Renumbered from R.S. 22:1804 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 2009, No. 503, § 1.

§ 366. Annual reports

By June first of each year, every vehicle mechanical breakdown insurer shall, file with the commissioner an audited financial statement for the immediately preceding year ending December thirty-first. The financial statement shall be audited by a certified public accounting firm which is acceptable to the commissioner. The commissioner may determine and require that additional information be submitted with the audited financial statements.

Renumbered from R.S. 22:1805 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2008. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 2009, No. 98, § 1.

§ 367. Reserves

Each vehicle mechanical breakdown insurer shall maintain loss reserves in such amounts as the commissioner deems sufficient.

Renumbered from R.S. 22:1806 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978.

§ 368. Contracts not in compliance

Any vehicle mechanical breakdown insurance policy issued in violation of any provisions of this Subpart shall be an enforceable and valid contract unless otherwise invalid.

Renumbered from R.S. 22:1807 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978.

§ 368.1. Filing of contracts

No vehicle mechanical breakdown insurance policy or application form, where written application is required and is to be attached to the policy, or any rider or endorsement of such a contract shall be issued, delivered, or used unless it has been filed with the commissioner of insurance. Each submission shall be accompanied by the fees provided for in R.S. 22:821.

Renumbered from R.S. 22:1807.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 818, § 1.

§ 369. Revocation or suspension of license

A. In accordance and compliance with R.S. 49:961, the commissioner may levy a fine not to exceed one thousand dollars per violation or revoke or suspend any license required by this Subpart should he find any of 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 commissioner, 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 an inspection as provided in R.S. 22:370.

(5) If the insurer fails to comply with any provision of this Subpart or a lawful order of the commissioner.

B. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1808 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2014, No. 80, § 1.

§ 369.1. Reinstatement of license

A. A vehicle mechanical breakdown insurer whose license has been suspended for failure to pay the annual renewal fee required by R.S. 22:362 shall have his license reinstated if the annual renewal fee is paid within ninety days of the date of suspension, provided all other requirements of this Subpart have been met.

B. A vehicle mechanical breakdown insurer whose license has been suspended for failure to file the annual audited financial statement required by R.S. 22:366 shall have his license reinstated if the annual audited financial statement is filed within ninety days of the deadline for filing provided in R.S. 22:366.

Added by Acts 2014, No. 80, § 1.

§ 370. Inspection

After furnishing fourteen days written notice, the commissioner or any

representative may inspect the records and reserves of any insurer licensed under this Subpart. The reasonable expense for inspection of records not available in Louisiana shall be borne by the insurer.

Renumbered from R.S. 22:1809 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978.

§ 371. Cease and desist order; penalty for violation

A. If the commissioner should determine that the provisions of this Subpart have been violated, the commissioner shall, in addition to the authority to revoke or suspend a license as provided in R.S. 22:369, have the authority to issue an order requiring such person or insurer violating the provisions of this Subpart, to cease and desist from such method, act, or practice. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

B. If no hearing is demanded by the aggrieved party or after a final order from the division of administrative law is issued withholding the commissioner's order, such person or insurer continues to violate the provisions of this Subpart, the commissioner may seek the enforcement of such order by civil legal action filed in the Nineteenth Judicial District Court. Any person who violates a cease and desist order 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.

Renumbered from R.S. 22:1810 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978. Amended by Acts 1990, No. 657, § 1; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 372. Rules and regulations

The commissioner may adopt such administrative rules as are necessary to implement the provisions of this Subpart.

Renumbered from R.S. 22:1811 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978.

§ 373. Scope and limitations

A. It is not the purpose of this Subpart 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 Subpart shall be exempt from the applicability of all other insurance laws of this state, except where such laws are specifically incorporated herein by reference.

Renumbered from R.S. 22:1812 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 520, § 1, eff. July 12, 1978.

SUBPART M. PROPERTY RESIDUAL VALUE INSURERS

§ 381. Definitions

As used in this Subpart:

(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, company, insurer, association, organization, reciprocal or inter-insurance exchange, partnership, business, trust, limited liability company, or corporation 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.

Renumbered from R.S. 22:1900 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 1986, No. 849, § 1; Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2009, No. 503, § 1.

§ 382. License required of property residual value insurer; notice of material change required

A. 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.

B. A licensee shall notify the commissioner within sixty days of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a license in this state. Material changes shall include but are not limited to the following:

(1) Changes in officers or directors.

(2) Changes in ownership.

(3) A change in the articles of incorporation.

(4) A merger.

(5) An addition or change of a trade name or "d/b/a".

(6) Cessation of business in Louisiana.

Renumbered from R.S. 22:1901 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2014, No. 82, § 1.

§ 383. Exceptions

Nothing in this Subpart shall have any effect upon contracts of casualty or property insurance issued on property in this state.

Renumbered from R.S. 22:1902 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981.

§ 384. Qualifications

The commissioner shall not license a property residual value insurer unless all of the following conditions are met:

(1) Applicant shall be solvent.

(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. 22:385.

(4) Applicant shall be in compliance with and continue to be in compliance with all applicable laws.

Renumbered from R.S. 22:1903 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2009, No. 503, § 1.

§ 385. 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 issued by a surety insurer authorized 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 such securities shall be the property of the property residual value insurer.

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 property residual value insurer's obligations to the policyholders are fulfilled.

Renumbered from R.S. 22:1904 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2009, No. 503, § 1.

§ 386. Annual reports

By June first of each year, every property residual value insurer shall, file with the commissioner an audited financial statement for the immediately preceding year ending December thirty-first. The financial statement shall be audited by a certified public accounting firm which is acceptable to the commissioner. The commissioner may determine and require that additional information be submitted with the audited financial statements.

Renumbered from R.S. 22:1905 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2009, No. 98, § 1.

§ 387. Reserves

Each property residual value insurer shall maintain loss reserves in such amounts as the commissioner deems sufficient.

Renumbered from R.S. 22:1906 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981.

§ 388. Contracts not in compliance

Any property residual value insurance policy issued in violation of any provisions of this Subpart shall be an enforceable and valid contract unless otherwise invalid.

Renumbered from R.S. 22:1907 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981.

§ 388.1. Filing of contracts

No property residual value insurance policy or application form, where written

application is required and is to be attached to the policy, or any rider or endorsement of such a contract shall be issued, delivered, or used unless it has been filed with the commissioner of insurance. Each submission shall be accompanied by the fees provided for in R.S. 22:821.

Renumbered from R.S. 22:1907.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 883, § 1. Amended by Acts 2009, No. 503, § 1.

§ 389. Revocation or suspension of license; fine

A. The commissioner may levy a fine not to exceed one thousand dollars per violation or revoke or suspend any license required by this Subpart in accordance and compliance with R.S. 49:961 for any of the following:

(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. 22:390.

(5) The insurer fails to comply with any provision of this Subpart or a lawful order of the commissioner.

B. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1908 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2009, No. 317, § 1; Acts 2014, No. 82, § 1.

§ 389.1. Reinstatement of license

A. A property residual value insurer whose license has been suspended for failure to pay the annual renewal fee required by R.S. 22:382 shall have his license reinstated if the annual renewal fee is paid within ninety days of the date of suspension, provided all other requirements of this Subpart have been met.

B. A property residual value insurer whose license has been suspended for failure to file the annual audited financial statement required by R.S. 22:386 shall have his license reinstated if the annual audited financial statement is filed within ninety days of the deadline for filing provided in R.S. 22:386.

Added by Acts 2014, No. 82, § 1.

§ 390. Inspection

After furnishing fourteen days written notice, the commissioner or his representative may inspect the records and reserves of any insurer licensed under this Subpart. The reasonable expense for inspection of records not available in

Louisiana shall be borne by the insurer.

Renumbered from R.S. 22:1909 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981.

§ 391. Cease and desist order; penalty for violation

A. If the commissioner determines that the provisions of this Subpart have been violated, he shall, in addition to the authority to revoke or suspend a license as provided in R.S. 22:389, have the authority to issue an order requiring such person or insurer violating the provisions of this Subpart, to cease and desist from such method, act, or practice. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

B. If no hearing is demanded by the aggrieved party or after a final order from the division of administrative law is issued upholding the commissioner's order, such person or insurer continues to violate the provisions of this Subpart, 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.

Renumbered from R.S. 22:1910 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2009, No. 317, § 1.

§ 392. Rules and regulations

The commissioner may adopt such administrative rules and regulations as are necessary to implement the provisions of this Subpart.

Renumbered from R.S. 22:1911 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981.

§ 393. Scope and limitations

A. Nothing in this Subpart shall alter or diminish any right, privilege, or authority granted to any insurance company under any other provisions of this Title.

B. All property residual value insurers operating pursuant to a license as required by this Subpart shall be exempt from the applicability of all other insurance laws of this state, except where such laws are specifically incorporated herein by reference.

Renumbered from R.S. 22:1912 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 472, § 1, eff. July 19, 1981. Amended by Acts 2009, No. 503, § 1.

§§ 394 to 397. [Blank]

SUBPART N. NON-PROFIT BENEFICIARY ORGANIZATIONS AND RISK INDEMNIFICATION TRUSTS

§ 401. Title; purpose

A. This Subpart may be cited as the "Nonprofit Risk Indemnification Trust Act."

B. The purpose of this Subpart 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.

Renumbered from R.S. 22:2041 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 402. 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 Subpart.

Renumbered from R.S. 22:2042 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 403. 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.

Renumbered from R.S. 22:2043 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 404. Limitation

A. 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.

B. Nothing in this Section shall prohibit a trust fund established under the provisions of this Subpart by an association comprised of tow truck owners or operators as defined in R.S. 32:1713 et seq., from indemnifying association members for physical damage and collision coverage on motor vehicles owned by association members.

Renumbered from R.S. 22:2044 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2. Amended by Acts 2006, No. 554, § 1.

§ 405. 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.

Renumbered from R.S. 22:2045 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 406. Written indemnification agreement

Every trust fund established under this Subpart 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.

Renumbered from R.S. 22:2046 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 407. 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.

Renumbered from R.S. 22:2047 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 408. 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.

Renumbered from R.S. 22:2048 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 409. 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 at least 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.

Renumbered from R.S. 22:2049 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2. Amended by Acts 2009, No. 503, § 1.

§ 410. 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.

Renumbered from R.S. 22:2050 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 411. 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.

Renumbered from R.S. 22:2051 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 412. 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.

Renumbered from R.S. 22:2052 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 413. Contracts with risk management 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 such trust funds. Fees paid to vendors for services provided shall not be excessive.

Renumbered from R.S. 22:2053 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2. Amended by Acts 2009, No. 503, § 1.

§ 414. 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.

Renumbered from R.S. 22:2054 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 415. 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.

Renumbered from R.S. 22:2055 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 416. 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.

Renumbered from R.S. 22:2056 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 417. 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.

Renumbered from R.S. 22:2057 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 418. Administrative rules

The commissioner may adopt rules to enforce and administer the requirements of this Subpart, according to the provisions of the Administrative Procedure Act.

Renumbered from R.S. 22:2058 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2.

§ 419. Trust funds not insurance

A trust fund established under this Subpart 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 Subpart and in R.S. 22:977 and 978.

Renumbered from R.S. 22:2059 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 574, § 2. Amended by Acts 1991, No. 933, § 1; Acts 2006, No. 396, § 1, eff. Jan. 1, 2007.

§ 420. Creation of trust funds prohibited

No trust fund authorized by this Subpart may be established to operate in this state after twelve noon on October 1, 2010.

Added by Acts 2010, No. 415, § 1, eff. June 21, 2010.

SUBPART O. SURPLUS LINES

§ 431. Purpose; necessity for regulation

This Subpart shall be liberally construed and applied to promote its underlying purposes which include:

(1) Protecting persons seeking insurance in this state.

(2) Facilitating the placement of surplus lines insurance with reputable and financially sound unauthorized insurers under the provisions of this Subpart.

(3) Establishing a system of regulation that permits orderly access to surplus lines insurance in this state and encourages authorized insurers to make new and innovative types of insurance available to consumers in this state.

(4) Providing a system through which persons may purchase insurance from approved unauthorized insurers or eligible unauthorized insurers pursuant to this Subpart.

(5) Protecting the revenues of this state.

(6) Providing a system pursuant to this Subpart that subjects unauthorized insurance activities in this state to the jurisdiction of the commissioner of insurance and state and federal courts in suits by or on behalf of the state.

Renumbered from R.S. 22:1248 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1340, § 1, eff. July 15, 1997. Amended by Acts 2013, No. 203, § 1, eff. June 10, 2013.

§ 432. Surplus lines insurance; procurement

Surplus lines insurance, as defined in R.S. 22:46, may be procured from a surplus lines insurer, as defined in R.S. 22:46, and shall be procured through a licensed surplus lines broker. It may be procured without regard to the availability of coverage from authorized insurers.

Renumbered from R.S. 22:1257 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1984, No. 938, § 1; Acts 1988, No. 191, § 1, eff. July 1, 1988; Acts 2004, No. 466, § 1, eff. Jan. 1, 2005; Acts 2009, No. 503, § 1; Acts 2013, No. 203, § 1, eff. June 10, 2013; Acts 2015, No. 193, § 1.

§ 433. Endorsement of contract

A. Each insurance policy or contract procured and delivered as surplus lines coverage pursuant to this Subpart shall have the following notice:

NOTICE

_____

This insurance policy is delivered as surplus lines coverage under the Louisiana Insurance Code.

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 types of policies issued by insurance companies 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 pursuant to Subsection A of this Section shall be:

(1) Prominently displayed in the color red or prominently offset by a black border.

(2) Printed or stamped on the policy or contract in bold and in not less than ten-point type.

(3) Signed by the surplus lines broker who procured the policy or contract.

Renumbered from R.S. 22:1258 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 291, § 1. Amended by Acts 1972, No. 241, § 1; Acts 1999, No. 868, § 1; Acts 2004, No. 466, § 1, eff. Jan. 1, 2005; Acts 2009, No. 503, § 1; Acts 2013, No. 203, § 1, eff. June 10, 2013.

§ 434. Surplus lines insurance valid

Insurance contracts procured as surplus lines coverage in accordance with this

Subpart 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.

Renumbered from R.S. 22:1259 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2004, No. 466, § 1, eff. Jan. 1, 2005; Acts 2009, No. 503, § 1; Acts 2015, No. 193, § 1.

§ 435. Solvency and eligibility requirements

A. A surplus lines broker shall place surplus lines insurance only with surplus lines insurers that are:

(1) Financially sound.

(2) Authorized in their domiciliary jurisdictions to write the type of insurance placed.

B. A surplus lines broker shall not place coverage with a surplus lines insurer, unless, at the time of placement, the surplus lines broker has determined that the surplus lines insurer qualifies under one of the following Paragraphs:

(1)(a) If it is a foreign insurer that it has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(i) The minimum capital and surplus requirements under the laws of this state.

(ii) Fifteen million dollars.

(b) The requirements of Subparagraph (a) of this Paragraph may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability 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 an unauthorized insurer's capital and surplus is less than four million five hundred thousand dollars.

(2)(a) If it is an alien insurer, it shall be listed by the International Insurers Department of the National Association of Insurance Commissioners on its Quarterly Listing of Alien Insurers.

(b) The commissioner may waive the requirement in Subparagraph (a) of this Paragraph upon an affirmative finding of the insurer's meeting the requirements for capital and surplus or acceptability pursuant to Paragraph (1) of this Subsection.

(3) If it is a domestic insurer, it is a domestic surplus lines insurer as provided for in R.S. 22:436.1.

C. In addition to any other statements or reports required by this Subpart, the commissioner of insurance may request from any surplus lines broker full and complete information respecting the financial stability, reputation, and

integrity of any unauthorized insurer with whom any such surplus lines broker has dealt, or proposes to deal, in the transaction of insurance business. The surplus lines broker shall promptly furnish in written or printed form so much of the information requested as he can produce.

Renumbered from R.S. 22:1262 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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, eff. July 15, 1997; Acts 1999, No. 868, § 1; Acts 2009, No. 503, § 1; Acts 2013, No. 203, § 1, eff. June 10, 2013; Acts 2015, No. 193, § 1.

§ 436. Approved unauthorized insurers; list; requirements; removal

A. The commissioner of insurance shall maintain a list of approved unauthorized insurers from those eligible unauthorized insurers that apply for approval and satisfy the criteria established by the commissioner. Placement on the list of approved unauthorized insurers shall be prima facie evidence that an unauthorized insurer meets the financial and eligibility criteria of R.S. 22:435(A) and (B).

B. To obtain and maintain placement on the list of approved unauthorized insurers, an unauthorized insurer shall comply with the provisions of R.S. 22:435 applicable to foreign or alien insurers, respectively, and shall annually file with the commissioner the following, unless available to the commissioner through the NAIC or from public sources:

(1) A copy of the insurer's annual statement as of the preceding December thirty-first, evidencing that the insurer has complied with the provisions of R.S. 22:435.

(2) 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.

(3) 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 commissioner no later than April fifteenth of each year.

C. The commissioner may remove an approved unauthorized insurer from the list if:

(1) The insurer fails to pay any required fee.

(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.

(4) The insurer is in unsound financial condition or has acted in an untrustworthy manner.

(5) The insurer no longer satisfies the requirements set forth in R.S. 22:435.

(6) The insurer has willfully violated the laws of this state.

(7) The insurer conducts improper claims practices, including but not limited to unfair trade practices as defined in Part IV of Chapter 7 of this Title, R.S. 22:1961 et seq.

D. 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 lines brokers may, at the option of the surplus lines broker, be sent by the commissioner via electronic mail.

E. 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.

Renumbered from R.S. 22:1262.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1985, No. 432, § 1, eff. July 10, 1985. Amended by Acts 1990, No. 885, § 1; Acts 1997, No. 310, § 1; Acts 1997, No. 310, § 1; Acts 1997, No. 1340, § 1, eff. July 15, 1997; Acts 2004, No. 466, § 1, eff. Jan. 1, 2005; Acts 2005, No. 167, § 1, eff. June 28, 2005; Acts 2009, No. 503, § 1; Acts 2013, No. 203, § 1, eff. June 10, 2013.

§ 436.1. Domestic surplus lines insurer

A. The commissioner may designate a domestic insurer as a domestic surplus lines insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than fifteen million dollars. The commissioner shall not approve an application until all outstanding fees and assessments owed pursuant to this Title are paid in full or satisfaction arrangements for their payment are established with the commissioner.

B. A domestic surplus lines insurer shall:

(1) Be limited in its authority in this state to providing surplus lines insurance.

(2) Be authorized to write any type of insurance in this state that may be placed with a surplus lines insurer pursuant to this Subpart.

(3) Be subject to the requirements of this Title applicable to domestic insurers except as follows:

(a) Part IV of Chapter 3 of this Title relative to taxes and exemptions.

(b) Subpart O of Part IV of Chapter 4 of this Title relative to ratemaking procedures and organizations except as required pursuant to R.S. 22:1456(B)(2) relative to public carrier vehicles.

(c) Chapter 10 of this Title relative to guaranty funds.

(4) Report to the commissioner all surplus lines business placed in this state in the manner required of an approved unauthorized insurer.

C. A domestic surplus lines insurer may write insurance in other jurisdictions with the approval of the commissioner.

Added by Acts 2015, No. 193, § 1.

§ 437. Records of surplus lines broker

A. Each licensed surplus lines 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 workers' 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 workers' compensation claims through such office or of the licensed claims adjuster retained by the insurer.

B. 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 lines broker, such examination shall be in compliance with and pursuant to the provisions of Chapter 8 of this Title, R.S. 22:1981 et seq., insofar as the provisions of that Chapter are applicable to such examination.

Renumbered from R.S. 22:1263 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1990, No. 885, § 1; Acts 2004, No. 466, § 1, eff. Jan. 1, 2005; Acts 2009, No. 503, § 1.

§ 438. Acknowledgment of applicant for insurance

A. Any licensed surplus lines broker that procures a personal lines policy with a surplus lines insurer shall obtain from the applicant for insurance no later than the date of binding coverage, an acknowledgment on a standardized form

promulgated by the commissioner of insurance which shall be maintained by the licensed surplus lines broker. The acknowledgment shall verify that:

(1) The applicant for insurance was expressly advised prior to placement of the surplus lines insurance.

(2) The insurance may be placed with a surplus lines insurer.

(3) In the event of insolvency of the insurer, losses shall not be paid by the Louisiana Insurance Guaranty Association.

(4) The applicant for insurance expressly authorizes the procurement of surplus lines insurance coverage.

(5) The coverage is being procured through a duly licensed surplus lines broker.

B. As long as the personal lines policy continues to be renewed by the same surplus lines insurer, there shall not be a need for new acknowledgments at each renewal. At renewal, if the personal lines policy is placed with a different surplus lines insurer, then a new acknowledgment shall be obtained in the manner outlined in Subsection A of this Section.

Renumbered from R.S. 22:1263.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 126, § 1. Amended by Acts 1999, No. 868, § 1; Acts 2009, No. 503, § 1; Acts 2013, No. 203, § 1, eff. June 10, 2013; Acts 2015, No. 193, § 1.

§ 439. Tax on surplus lines

A. (1) There shall be a tax of four and eighty-five one hundredths of one percent per annum on the gross premium for all surplus lines of insurance for which Louisiana is the home state of the policyholder as defined in R.S. 22:46(8.1). The commissioner shall collect the tax and deposit it with the state treasurer who shall credit it to the state general fund.

(2) On or before March first, June first, September first, and December first of each year, each surplus lines broker shall transmit to the commissioner a surplus lines tax report and remit the tax payable pursuant to this Subsection. The commissioner shall prescribe the manner and form of the report, which shall include all of the following:

(a) All new and renewal policies for the calendar quarter in which the effective date of the policy falls.

(b) All other premium transactions for the calendar quarter in which the invoice falls.

(c) Any additional information required by the commissioner.

(3) The commissioner shall not require a quarterly report for any quarter in which a surplus lines broker has no surplus lines premium to report. The commissioner shall require the filing of the report due on or before March first in order to certify the reporting of all surplus lines business conducted during the calendar year or the absence of any business during the calendar year.

B. Every person placing insurance without a licensed Louisiana producer or surplus lines broker shall transmit a report and remit the tax to the commissioner pursuant to Subsection A of this Section.

C. The tax imposed on surplus lines pursuant to this Section shall not apply to the purchase of excess insurance obtained by an interlocal risk management agency pursuant to R.S. 13:5575 or R.S. 33:1359.

D. (1) The tax imposed pursuant to this Section shall not apply to the purchase of insurance by a college, university, school, institution, or program that is under the supervision or management of a system board of supervisors provided for in R.S. 17:3215 through 3217.1.

(2) The tax imposed pursuant to this Section shall not apply to the purchase of insurance by political subdivisions having a population of not less than three hundred fifty thousand persons according to the latest federal decennial census.

Renumbered from R.S. 22:1265 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1; Acts 2011, No. 361, § 1, eff. July 1, 2011; Acts 2013, No. 203, § 1, eff. June 10, 2013; Acts 2015, No. 386, § 1, eff. July 1, 2015, except subsecs. A and B eff. Oct. 1, 2015.

Repeal of Acts 2011, No. 361, § 2; Effective Date of Withdrawal from Nonadmitted Insurance Multi-State Agreement; Effective Date of Act—Acts 2015, No. 386

Sections 2 to 4 of Acts 2015, No. 386 provide:

"Section 2. Section 2 of Act No. 361 of the 2011 Regular Session of the Legislature of Louisiana is hereby repealed in its entirety.

"Section 3. Withdrawal from the Nonadmitted Insurance Multi-state Agreement shall be effective on and after October 1, 2015.

"Section 4. (A) Except as provided for in Subsection (B) of this Section, the provisions of this Act shall become effective on October 1, 2015.

"(B) R.S. 22:439(C) and (D) as amended and reenacted by this Act shall become effective on July 1, 2015."

Nonadmitted Insurance Multi-State Agreement—Acts 2011, No. 361

Prior to repeal of § 2 by Acts 2015, No. 386, section 2 of Acts 2011, No. 361(§ 1 of which amended this section) provided:

"Section 2. The commissioner shall on behalf of the state of Louisiana enter into the Nonadmitted Insurance Multi-State Agreement or other cooperative compacts or agreements with other states."

Nonadmitted Insurance Multi-State Agreement; Effective Date—Acts 2011, No. 361

Section 3 of Acts 2011, No. 361 (§ 1 of which amended this section) provided:

"Section 3. Section 1 of this Act shall become effective when the commissioner on behalf of the state of Louisiana enters into the Nonadmitted Insurance Multi-State Agreement or other cooperative compacts or agreements with other states. Upon execution of a Nonadmitted Insurance Multi-State Agreement or other cooperative compact or agreement with another state pursuant to this Act, the commissioner shall notify the Louisiana State Law Institute as to the execution of the agreement or compact and its effective date in order that the Louisiana State Law Institute can direct the appropriate entities as to the effective date of the statutory provisions contained in this Act."

Pursuant to former § 2 and § 3 of Acts 2011, No. 361, the Commissioner of Insurance notified the Louisiana State Law Institute of his signing of the Nonadmitted Insurance Multi-State Agreement (NIMA), effective in Louisiana as of July 1, 2011.

§ 440. Penalty for failure to file statement or remit tax

In case of any failure of a surplus lines broker to make a report or to make payment of the tax provided by R.S. 22:439, ten percent 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. 22:439, neglect will be presumed and the ten percent 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 lines 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.

Renumbered from R.S. 22:1266 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1966, No. 176, § 1; Acts 2009, No. 503, § 1.

§ 441. 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. 22:439 or to remit required taxes on surplus lines premiums as required by this Subpart.

(2) If the broker fails to maintain the required records and accounts from this state as prescribed by R.S. 22:437, or to allow the commissioner of insurance to examine his records as required by this Subpart.

(3) For closing of the surplus lines 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 Subpart.

(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. 22:1554.

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 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 lines broker's license.

C. The procedures provided by this Code for the denial, suspension, revocation, or refusal to renew or reinstate a 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 a producer shall be applicable to the levying of fines against a surplus line broker.

D. No surplus lines 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.

Renumbered from R.S. 22:1267 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. Jan. 1, 2005; Acts 2009, No. 503, § 1.

§ 442. Legal process against unauthorized 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 lines contract, pursuant to this Subpart, 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 registered or certified mail or by commercial courier as defined in R.S. 13:3204(D). 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.

Renumbered from R.S. 22:1268 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1; Acts 2012, No. 544, § 3.

§ 443. Exemptions

A. The provisions of R.S. 22:432 through 442, 444, and 1910 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. 22:439 at the rate of four and eighty-five one hundredths of one 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. 22:435, notwithstanding the provisions of R.S. 22:1902, 1903, and 1906, and must show on any document issued by 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 policyholder or his 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 property or operation of railroads engaged in interstate commerce.

(3) 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 workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of such aircraft.

B. (1) Surplus lines 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 lines insurance under this Subpart. 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 lines 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.

(2) Notwithstanding anything to the contrary herein contained, the rates for the exempt lines of insurance set out in Paragraphs (A)(1), (2), (3), and (4) of this Section shall not be regulated.

Renumbered from R.S. 22:1269 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 264, § 1. Amended by Acts 1960, No. 183, § 1; Acts 1970, No. 185, § 1; Acts 1986, No. 749, § 1; Acts 1999, No. 868, § 1; Acts 2009, No. 503, § 1; Acts 2015, No. 386, § 1, eff. Oct. 1, 2015.

§ 444. Records of insureds

Every person for whom insurance has been placed with an unauthorized insurer pursuant to or in violation of this Subpart 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.

Renumbered from R.S. 22:1270 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 445. Tontine funds; sales prohibited

A. The sale by any person 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.

Renumbered from R.S. 22:1271 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1964, No. 385, §§ 1, 2. Amended by Acts 2009, No. 503, § 1.

§ 446. Surplus lines insurance; exemption from form and rate filing and approval

Surplus lines insurers shall not be required to file or seek approval of their forms and rates.

Added by Acts 2010, No. 189, § 1, eff. June 9, 2010. Amended by Acts 2015, No. 193, § 1.

SUBPART P. GROUP SELF-INSURERS

§ 451. Scope of provisions

A. This Subpart shall be applicable to and shall regulate self-insurers and self-insurance plans, as defined in this Subpart, which are subject to jurisdiction of the commissioner of insurance under this Title. This Subpart shall not be applicable to any workers' compensation plan, except as otherwise provided in this Subpart. This Subpart shall not apply to any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950.

B. Regulation under this Subpart 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 Subpart shall not be considered or treated as an insurer or insurance policy solely because of such regulation.

Renumbered from R.S. 22:3001 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 1992, No. 612, § 1; Acts 2009, No. 503, § 1; Acts 2010, No. 794, § 1.

§ 452. Definitions

For purposes of this Subpart, 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 any arrangement or trust formed under Subpart J of Part I of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, or 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. 22:463, the Office of Group Benefits, plans of political subdivisions, health maintenance organizations regulated under the Health Maintenance Organization Act, R.S. 22:241 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 Subpart 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.

(4) "Claims liability" means the total of all incurred and unpaid claims for allowable benefits under a self-insurance plan, including a multiple employer welfare arrangement, that are not reimbursed or reimbursable by excess of loss insurance, subrogation, or other sources.

(5) "Net assets" means the excess of the assets of a self-insurance plan, including a multiple employer welfare arrangement, minus the liabilities of the plan. The liabilities of a self-insurance plan include the claims liability of the plan.

Renumbered from R.S. 22:3002 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 1992, No. 775, § 1; Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2010, No. 794, § 1; Acts 2015, No. 455, § 1.

§ 453. 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 Subpart shall be considered an unauthorized insurer within the meaning of Subpart O of this Part, R.S. 22:431 et seq., and Part I of Chapter 7 of this Title, R.S. 22:1901 et seq., 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 all of the following items:

(1) A copy of the self-insurer'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) Biographical background information, on a form prescribed by the commissioner for each person who controls, directly or indirectly, ten percent or more of the self-insurer and for each director and officer of the self-insurer.

(4) A plan of operation which clearly indicates the method of operation of the self-insurer including all of the following items:

(a) The types and limits of insurance to be provided.

(b) Pro forma financial statements for a period covering three years, which shall include a balance sheet, income statement, and cash flow statement.

(c) The amount and liquidity of its assets relative to the risks to be assumed by the self-insurer.

(d) The expertise, experience, and character of the persons or entities which will manage the self-insurer.

(e) A description of the self-insurer's stop-loss or excess program.

(f) A description of the self-insurer's underwriting policy, including the person or entity which will perform these functions.

(g) A description of the self-insurer's claims handling procedures, including the person or entity that will perform these functions.

(h) A description of the self-insurer's investment policy.

(i) The overall soundness of the plan of operation of the self-insurer.

(j) A description of the self-insurer's rate-making policies and procedures.

(5) A feasibility study or other analysis involving the self-insurance plan prepared by a qualified actuary.

(6) 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.

(7) 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.

(8) A copy of a fidelity bond which bond shall comply with all of the following:

(a) Provides protection to the self-insurer against acts of fraud or dishonesty by persons servicing the self-insurer.

(b) Provides coverage for each person responsible for servicing the self-insurer.

(c) Is in an amount equal to the greater of ten percent of the premiums and contributions received by the self-insurer or ten percent of the benefits paid, during the preceding calendar year, with a minimum amount of ten thousand dollars and a maximum amount of five hundred thousand dollars.

(9) A copy of all advertising and marketing materials, including the marketing plan.

(10) A statement by the self-insurer certifying that the self-insurance plan is in compliance with all applicable provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.).

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 Subpart.

Renumbered from R.S. 22:3003 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 2009, No. 503, § 1; Acts 2012, No. 680, § 1, eff. June 7, 2012.

§ 454. Insolvency deposit

A. All self-insurers shall, before receiving a certificate of authority, deposit with the commissioner 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 self-insurer has deposited cash, or bonds of the United States, the state of Louisiana, or any political subdivision of the

state, of the par value of not less than the greater of either one of the following items:

(1) One hundred thousand dollars.

(2)(a) Thirty percent of the self-insurer's outstanding Louisiana-related reserve liabilities. For the purposes of this Subsection, reserve liabilities shall be computed with proper regard for the following items:

(i) Known claims paid and outstanding.

(ii) A history of incurred but not reported claims.

(iii) Claims handling expenses.

(iv) Unearned premium.

(v) An estimate for bad debts.

(vi) A trend factor.

(vii) A margin for error.

(b) All securities deposited pursuant to this Subsection shall be held in trust for the benefit and protection of and as security for all policyholders of the self-insurer making such deposit.

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, D. Repealed by Acts 2012, No. 680, § 2, eff. June 7, 2012.

E. Repealed by Acts 2009, No. 503, § 2.

Renumbered from R.S. 22:3004 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts

2012, No. 680, § 1, eff. June 7, 2012.

§ 455. Administrators; license

An administrator of a self-insurance plan shall be licensed as a life and health insurance producer and shall be subject to all laws and regulations governing life and health insurance producers as set forth in R.S. 22:1541 through 1554 and 1556 through 1565.

Renumbered from R.S. 22:3005 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2009, No. 503, § 1.

§ 456. Producers; appointment

A. Any self-insurer who has been issued a certificate of authority under this Subpart may contract with and appoint as its representatives in this state, as its producer or producers, any person or persons licensed as a life and health producer under Chapter 5 of this Title, R.S. 22:1541 et seq. No solicitation of insurance shall be made by any producer 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 producer within thirty days after receipt of the self-insurer's appointment of such producer, the producer 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 producers 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 producer is revoked by the commissioner or until cancelled by the self-insurer upon written notice to the producer and the commissioner.

C. Any self-insurer who violates the provisions of this Section shall be fined the sum of ten dollars for each producer's appointment received after the first day of March of each year.

Renumbered from R.S. 22:3006 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 2009, No. 503, § 1.

§ 457. Producers; 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 Subpart.

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. After ten days' notice, the commissioner may revoke, suspend, or refuse to renew a producer's license, or may levy a fine not to exceed two thousand five hundred dollars against a producer who has been found by the commissioner to have violated the provisions of this Section. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:3007 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 458. Self-insured trusts

The following requirements shall be met in addition to all other provisions of this Subpart where any self-insurance plan is effected, maintained, and operated under a trust agreement:

(1) A self-insurer shall maintain at all times unimpaired net assets of not less than one million dollars. The net assets required to be maintained pursuant to this Section shall be in the form of cash, cash equivalents, or bonds or evidences of indebtedness which are direct general obligations or which are secured or guaranteed as to principal and interest by the government of the United States, or any state of the United States.

(2) The employers in the self-insurance plan shall be members of an association or group of five or more businesses that are in the same trade or industry, including closely related businesses that provide support, services, or supplies primarily to that trade or industry.

(3) 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.

(4) Trustees shall be bonded in an amount not less than one hundred fifty thousand dollars from a licensed surety company.

(5) Investment of plan funds is subject to the same restrictions which are applicable to insurers under this Title.

Renumbered from R.S. 22:3008 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 2012, No. 680, § 1, eff. June 7, 2012.

§ 458.1. Association-sponsored self-insured trust

A. A trade or professional association that effects, maintains, and operates a self-insured trust for the benefit of its members and their employees, meets all the requirements of this Section, and complies with all other provisions of this

Subpart except R.S. 22:454 and 458 shall be deemed exempt from the provisions of R.S. 22:454 and 458. A self-insured trust operated under the provisions of this Section shall be designated an association-sponsored self-insured trust.

B. For the purposes of this Section, "association" means an active trade or professional association which satisfies all of the following:

(1) Meets either of the following criteria:

(a) Is a tax exempt organization approved by the Internal Revenue Service under the provisions of 26 U.S.C. § 501.

(b) Is a nonprofit corporation organized under Chapter 2 of Title 12 of the Louisiana Revised Statutes of 1950.

(2) Provides services to its membership so that the primary function of the trade or professional association is not the sponsorship, operation, or management of a fund, or related employee safety program, or other related activities. The association shall have, for a period of at least ten years prior to the date of application, satisfied all of the following requirements:

(a) Held regular meetings of the board on no less than an annual basis.

(b) Produced a newsletter, on no less than an annual basis, which was mailed, via United States mail or sent by electronic mail, to each member.

(3) Is chartered and domiciled in the state of Louisiana and has been in existence since January of 1950.

(4) Is comprised of professionals that possess licenses issued by an authority of the state in order to conduct the business of the profession. An association whose membership includes members of the profession who no longer possess licenses because they have retired shall be deemed to have satisfied this requirement if the total number of retired members comprises no more than twenty percent of the association's overall membership.

C. An association-sponsored self-insured trust shall deposit with the commissioner 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 self-insurer has deposited cash or bonds of the United States, the state of Louisiana, or any political subdivision of the state, of the par value of not less than the greater of either one of the following items:

(1) One hundred thousand dollars.

(2)(a) Thirty percent of the self-insurer's outstanding Louisiana-related reserve liabilities. For the purposes of this Subsection, reserve liabilities shall be computed with proper regard for the following items:

(i) Known claims paid and outstanding.

(ii) A history of incurred but not reported claims.

(iii) Claims handling expenses.

(iv) Unearned premium.

(v) An estimate for bad debts.

(vi) A trend factor.

(vii) A margin for error.

(b) All securities deposited pursuant to this Subsection shall be held in trust for the benefit and protection of and as security for all policyholders of the self-insurer making such deposit.

D. An association-sponsored self-insured trust shall:

(1) Maintain at all times during the first year of operations unimpaired net assets of not less than one hundred thousand dollars. The net assets required to be maintained pursuant to this Section shall be in the form of cash, cash equivalents, or bonds or evidences of indebtedness which are direct general obligations or which are secured or guaranteed as to principal and interest by the government of the United States, or any state of the United States.

(2) Have applications from not less than two employers and plan to provide similar benefits for not less than one hundred participating employees.

(3) Maintain contribution rates for participation under the arrangement that equal or exceed a funding level established by a report prepared by an actuarial firm.

E. (1) The employers in the self-insurance plan shall be members of an association as defined in this Section.

(2) Each employer member participating in the association-sponsored self-insurance plan shall sign an indemnity agreement that is also signed by representatives of the association and the trust. The agreement shall contain acknowledgment by all parties of their assumption of liabilities as set forth in this Section.

(3) The association sponsoring the trust shall be responsible for unpaid claims liability of the trust. Employer members participating in the self-insurance plan shall be in solido guarantors of liabilities of the trust not satisfied by the association.

(4) A board of trustees shall serve as fund managers on behalf of participants. Trustees shall be plan participants. Trustees shall be elected by participating employers or by association members who are plan participants. No participating employer may be represented by more than one trustee. A minimum of three and a maximum of ten trustees may be elected. Trustees may not receive compensation but may be reimbursed for actual expenses incurred in connection with duties as trustee.

(5) Trustees shall be bonded in an amount not less than one hundred thousand dollars from a licensed surety company.

(6) Investment of plan funds is subject to the same restrictions which are applicable to insurers under this Title.

F. (1) In the event that an association-sponsored self-insured trust is insolvent, then in addition to any other provision of law or regulation, the department shall require that the trust file in writing within sixty days a plan signed by the board of trustees. For purposes of this Subpart, an insolvency shall be defined as the condition existing when the trust's liabilities before member distribution payable or dividend payable are greater than the trust's assets determined in accordance with generally accepted accounting principles as delineated in the trust's financial statement audited by an independent certified public accountant. For the purpose of determining insolvency, assets shall not include intangible property, such as patents, trade names, or goodwill. The plan submitted by the trust to eliminate the insolvency shall set forth in detail the means by which the trust intends to eliminate the insolvency which may include payments by the association, assessments of the members participating in the trust's self-insurance plan, or a combination thereof. The trust shall also include the timetable for the implementation of the plan and requirements for reporting to the department. The department shall review the plan submitted by the trust and notify the trust of the plan's approval or disapproval within thirty days of the department's receipt of the plan.

(2) Upon determination by the department that a plan submitted by the trust is disapproved or that a trust is not implementing a plan in accordance with the terms of the plan, it shall so notify the trust in writing of such determination.

(3) Should a trust fail to file a plan to eliminate an insolvency as required pursuant to this Section, or should the department notify a trust that such plan has been disapproved or that the trust is not implementing the plan according to the plan, the department shall have the following powers and authority in addition to any other powers and authority granted under law:

(a) The department may order the trust to immediately levy an assessment upon the association, the members of the trust, or both, sufficient to eliminate the insolvency.

(b) Should the trust fail or refuse to levy the assessment, the department may, in the name of the trust, levy such assessment upon the association, the members of the trust, or both, sufficient to eliminate the insolvency.

G. Association-sponsored self-insured trusts are not members of either the Louisiana Insurance Guaranty Association or the Louisiana Life and Health Insurance Guaranty Association, nor shall either be liable for any claims or increments of claims made against any association-sponsored self-insured trust.

Added by Acts 2015, No. 455, § 1.

§ 459. Excess stop-loss coverage

A. 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. 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 prior to any subsequent 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.

B. The self-insurer shall possess a written commitment, binder, or policy for stop-loss insurance issued by an insurer authorized to do business in this state and that the commitment, binder, or policy provides all of the following items:

(1) At least thirty days' notice to the commissioner of any cancellation or nonrenewal of coverage.

(2) Both specific and aggregate coverage with an aggregate retention of not more than one-hundred twenty-five percent of the amount of expected claims for the next plan year and a specific retention amount annually determined by the actuarial opinion required by R.S. 22:463(B).

(3) Both the specific and aggregate coverage required in Paragraph (2) of this Subsection shall require all claims to be submitted within ninety days after the claim is incurred and provide a twelve-month claims incurred period and at least a fifteen-month paid claims period for each policy year.

C. On the application of a self-insurer, the commissioner may waive or reduce the requirement for aggregate stop-loss insurance coverage required by this Section on a determination that the interests of the participating employers and employees are adequately protected based on the level of aggregate stop-loss insurance recommended by the actuary as required by R.S. 22:463(B).

Renumbered from R.S. 22:3009 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 857, § 1. Amended by Acts 1990, No. 902, § 1; Acts 2012, No. 680, § 1, eff. June 7, 2012; Acts 2015, No. 455, § 1.

§ 460. 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 producers of the elements of coverage, including the amount of any reinsurance or "stop-loss" insurance in effect.

Renumbered from R.S. 22:3010 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 2009, No. 503, § 1.

§ 461. Annual audit

A. Each self-insurer shall cause to be conducted an annual audit 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.

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 generally accepted 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 items:

(1) The report of the independent certified public accountant.

(2) A balance sheet reporting admitted assets, liabilities, and net assets.

(3) A statement of gain or loss from operations.

(4) A statement of cash flows.

(5) A statement of changes in net assets.

(6) Notes to financial statements. These notes shall be those required by generally accepted accounting principles and shall include the following items:

(a) A reconciliation of difference, if any, between the audited statutory financial statements and the annual statement filed pursuant to this Subpart 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 self-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 audited by an independent certified public accountant. The audit 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 Subpart shall require the accountant to make available for review by the commissioner, the workpapers prepared in the conduct of his audit. The self-insurer shall require that the accountant retain the audit workpapers or 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 workpapers 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 audit pursuant to this Section shall nonetheless remain the property of the certified public accountant.

I. Repealed by Acts 2012, No. 680, § 2, eff. June 7, 2012.

J. Repealed by Acts 2010, No. 794, § 4.

Renumbered from R.S. 22:3011 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 1992, No. 612, § 1; Acts 2009, No. 503, § 1; Acts 2012, No. 680, § 1, eff. June 7, 2012.

§ 462. 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.

H. In lieu of an examination under this Section of any foreign self-insurer licensed in this state, the commissioner may accept an examination report on the self-insurer as prepared by the department for the self-insurer's state of domicile if the insurance department was, at the time of the examination, accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program and 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 that accredited state insurance department, and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their state insurance department.

Renumbered from R.S. 22:3012 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 1997, No. 1449, § 1; Acts 2012, No. 680, § 1, eff. June 7, 2012.

§ 463. Annual reports; actuarial opinions

A. 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.

B. (1) Each self-insurer shall file, within ninety days of the end of the fiscal year, an actuarial opinion prepared and certified by an actuary who meets the following requirements:

(a) The actuary is not an employee of the self-insurer.

(b) The actuary is a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, or an enrolled actuary under the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.).

(2) The actuarial opinion required under this Subsection shall include the following items:

(a) A description of the actuarial soundness of the self-insurer, including any actions recommended to improve the actuarial soundness of the arrangement.

(b) The amount of reserves recommended to be maintained by the arrangement.

(c) The level of specific and aggregate stop-loss insurance recommended to be maintained by the arrangement.

C. (1) Reserves required by this Section shall be computed with proper actuarial regard for the following items:

(a) Known claims, paid and outstanding.

(b) A history of incurred but not reported claims.

(c) Claims handling expenses.

(d) Unearned premium.

(e) An estimate for bad debts.

(f) A trend factor.

(g) A margin for error.

(2) Reserves required by this Section shall be maintained in cash, cash equivalents, or bonds or evidences of indebtedness which are direct general obligations or which are secured or guaranteed as to principal and interest by the government of the United States, or any state of the United States.

Renumbered from R.S. 22:3013 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 1992, No. 775, § 1; Acts 2012, No. 680, § 1, eff. June 7, 2012.

§ 464. 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.

Renumbered from R.S. 22:3014 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1.

§ 465. Insolvency of plan

When the commissioner, after examination or review of the audit statement required under R.S. 22:463, 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 R.S. 22:73 and 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq.

Renumbered from R.S. 22:3015 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 2009, No. 503, § 1.

§ 466. Transaction of business

A. 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 Subpart and of any other applicable provisions of this Title, including R.S. 22:1824.

B. Each self-insurer shall pay fees in advance in the amount specified in R.S. 22:821 for its filings, certificates, copies, and other services specified therein which are applicable to self-insurers.

C. The commissioner may take any action available to him under this Title to ensure compliance with and to enforce the provisions of this Subpart.

Renumbered from R.S. 22:3016 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 1993, No. 653, § 1; Acts 2009, No. 503, § 1.

§ 467. Duties of commissioner; rules and regulations

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 Subpart.

Renumbered from R.S. 22:3017 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 902, § 1. Amended by Acts 2009, No. 503, § 1.

§ 468. 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.

Renumbered from R.S. 22:3018 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 944, § 1.

§ 469. Inherited metabolic diseases; coverage for food products

A. Every self-insurer and self-insurance plan, as defined in this Subpart, which are subject to the jurisdiction of the commissioner under 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. Repealed by Acts 2009, No. 503, § 2.

Renumbered from R.S. 22:3018.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 829, § 1. Amended by Acts 2009, No. 503, § 1.

SUBPART Q. RISK RETENTION GROUPS

§ 481. Purpose; title

A. The purpose of this Subpart 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.[1]

B. This Subpart shall be known and may be cited as the "Risk Retention Group Law".

Renumbered from R.S. 22:2071 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 2009, No. 503, § 1.

[1] Pub.L. 99-563; see, generally, 15 U.S.C.A. § 3901 et seq.; 42 U.S.C.A. § 9671 et seq.

§ 482. Definitions

As used in this Subpart, 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.[1]

(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 [2] 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 (e) 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.

Renumbered from R.S. 22:2072 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 1995, No. 1203, § 1, eff. June 29, 1995; Acts 2009, No. 503, § 1.

[1] See, generally, 15 U.S.C.A. § 3901 et seq.; 42 U.S.C.A. § 9671 et seq.

[2] Pub.L. 97-45, 98-193, 99-563; see, generally, 15 U.S.C.A. § 3901 et seq.

§ 483. 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 Subpart, 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. 22:484 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.

Renumbered from R.S. 22:2073 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 1995, No. 1203, § 1, eff. June 29, 1995; Acts 2009, No. 503, § 1.

§ 484. 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.[1] 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. 22:482 (12).

(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 meets both of the following:

(a) Was defined in the Product Liability Risk Retention Act of 1981 [2] before the date of the enactment of this Act.

(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. 22:821.

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. 22:482.

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 producers 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 producers 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 producers 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. 22:492. 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 this 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.

Renumbered from R.S. 22:2074 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 1995, No. 1203, § 1, eff. June 29, 1995; Acts 2004, No. 376, § 1; Acts 2009, No. 503, § 1.

[1] Pub.L. 99-563; see, generally, 15 U.S.C.A. § 3901 et seq.; 42 U.S.C.A. § 9671 et seq.

[2] Pub.L. 97-45, 98-193, 99-563; see, generally, 15 U.S.C.A. § 3901 et seq.

§ 485. 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 meets any one of the following conditions:

(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.

Renumbered from R.S. 22:2074.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 935, § 1. Amended by Acts 2004, No. 376, § 1; Acts 2009, No. 503, § 1.

§ 486. 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.

Renumbered from R.S. 22:2075 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987.

§ 487. Repealed by Acts 2009, No. 503, § 2

§ 488. 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.

Renumbered from R.S. 22:2077 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987.

§ 489. 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. 22:490 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. 22:482(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 [1] 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.

Renumbered from R.S. 22:2078 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 1995, No. 1203, § 1, eff. June 29, 1995; Acts 1999, No. 299, § 1, eff. June 11, 1999.

[1] Pub.L. 97-45, 98-193, 99-563; see, generally, 15 U.S.C.A. § 3901 et seq.

§ 490. Registration and annual renewal; fees

Upon registration with the department, each risk purchasing group shall pay the department the fee specified in R.S. 22:821(B)(18)(a). 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 the renewal fee specified in R.S. 22:821(B)(18)(b) to the department.

Renumbered from R.S. 22:2078.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 299, § 1, eff. June 11, 1999. Amended by Acts 2009, No. 503, § 1.

§ 491. 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 producer acting pursuant to the 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.

Renumbered from R.S. 22:2079 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 1995, No. 1203, § 1, eff. June 29, 1995; Acts 2009, No. 503, § 1.

§ 492. Administrative and procedural authority regarding risk retention groups and purchasing groups

The commissioner may use any of the powers established under this Code 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.

Renumbered from R.S. 22:2080 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 2009, No. 503, § 1.

§ 493. Penalties

A risk retention group which violates any provision of this Subpart shall be subject to fines and penalties applicable to licensed insurers generally, including revocation of its registration and the right to do business in this state.

Renumbered from R.S. 22:2081 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 2009, No. 503, § 1.

§ 494. Duty on producers to obtain license

Any person acting, or offering to act, as a producer 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 R.S. 22:1541 through 1554 and 1556 through 1565.

Renumbered from R.S. 22:2082 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987. Amended by Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2009, No. 503, § 1.

§ 495. 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.

Renumbered from R.S. 22:2083 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987.

§ 496. 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 Subpart.

Renumbered from R.S. 22:2084 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 462, § 1, eff. Sept. 1, 1987.

§ 497. Repealed by Acts 2009, No. 503, § 2

§ 498. Policyholder's liability

A. Notwithstanding any other provisions in this Subpart, 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.

Renumbered from R.S. 22:2086 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 138, § 1. Amended by Acts 2009, No. 503, § 1.

SUBPART R. TITLE INSURANCE

§ 511. Title; purpose

A. This Subpart shall be known and cited as the "Louisiana Title Insurance Act".

B. The purpose of this Subpart 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 producers, and the escrow, accounting, closing, and settlement practices of insurers and producers wherein title insurance is issued or contemplated to be issued.

Renumbered from R.S. 22:2092.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 512. Definitions

As used only in this Subpart, the following words are defined as:

(1)(a) "Abstract" shall mean a written history, synopsis, or summary of the recorded instruments in the public records affecting the title to immovable

property that: (i) is prepared and certified by the abstractor in accordance with the minimum search periods and requirements of a title opinion as set forth in Paragraph (17) of this Section; (ii) includes a photocopy or electronic copy of such recorded instruments, or extracts of such recorded instruments prepared by the abstractor who personally reviewed such recorded instruments; and (iii) is dated and signed by the abstractor and presented to an attorney duly licensed and authorized to practice law in Louisiana, as set forth in Paragraph (17) of this Section and R.S. 37:212, for examination.

(b) For the purpose of this Paragraph, "public records" shall mean all instruments, including actual attachments thereto, which are recorded in the mortgage and conveyance records maintained by the clerk of court of the parish in which the property is situated, and the ad valorem property tax records for the parish and political subdivision in which the property is situated.

(c) Nothing in this Section prohibits any attorney duly licensed and authorized to practice law in Louisiana from personally reviewing and examining the public records in order to certify or give an opinion as to the title to 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 producer, 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 producer.

(7) "Escrow account" shall mean the demand deposit account maintained by a title insurer or title insurance producer at a qualified financial institution into which the insurer or producer 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 producer 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 producer 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 producer" or "producer" 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 the public records or a personal examination of an abstract. Such examinations shall be conducted and title opinion rendered only by an attorney duly licensed and authorized to practice law in Louisiana as provided in R.S. 37:212. The examination and resulting opinion, if it furnishes the basis of a title insurance report or title insurance policy relating to immovable property, shall be reduced to writing by the attorney. The title opinion shall contain the following:

(aa) Complete name of individuals with an ownership or other interest in the property.

(bb) Complete list of all encumbrances, mortgages, judgments, liens, and privileges. This list shall contain the name of secured creditors, date filed, amounts, and recordation information. For federal judgments, a search of the mortgage records shall be made for a period of twenty years. However, such time period requirement shall not apply to any transaction made prior to and on January 1, 2013, by the Road Home Corporation, The Louisiana Land Trust, or any political subdivision, of property originally acquired in connection with the Road Home Program.

(cc) Complete list of all servitudes, rights-of-way, leases, options, rights of first refusal, and usufructs encumbering the property.

(dd) Legal description of property examined.

(ee) Any curative measures which are required in order to render title merchantable.

(ff) All parish and municipal property taxes which are past due.

(gg) Length of examiner's search and date of earliest recorded instrument reviewed by the examiner. If the transaction being insured is a sale, the minimum search period shall be thirty years, or longer, if necessary, in order to reach an arms-length sale between unrelated, third parties. If only a mortgage is being insured, then the search shall be for a minimum of ten years or two links in the chain of title, whichever is greater. However, such minimum search periods for a sale or mortgage shall not apply to any transaction made prior to and on January 1, 2013, by the Road Home Corporation, The Louisiana Land Trust, or any political subdivision, of property originally acquired in connection with the Road Home Program.

(hh) Name and attorney bar roll number of the examining attorney.

(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 Subpart.

(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.

Renumbered from R.S. 22:2092.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2006, No. 828, § 1; Acts 2009, No. 503, § 1; Acts 2010, No. 1028, § 1; Acts 2011, No. 325, § 1, eff. Jan. 1, 2012.

Application—Acts 2010, No. 1028

Section 2 of Acts 2010, No. 1028 (§ 1 of which amended the introductory paragraph of subpar. (17)(b) and subitems (17)(b)(vi)(bb) and (17)(b)(vi)(gg) of this section) provides:

"Section 2. The provisions of this Act shall apply to all transactions occurring on or after September 1, 2010, except as otherwise provided by R.S. 22:512(17)(b)(vi)(bb) and (gg)."

§ 513. Title insurers and producers; qualifications

Only those persons authorized as a title insurer or producer 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 a producer licensed in this state under this Subpart or by an employee of a title insurer issuing the title insurance policies and reports when such employee is a producer licensed in this state under this Subpart.

Renumbered from R.S. 22:2092.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 513.1. Title insurance; identification of examining attorney and title producer

A. Every sale, conveyance, transfer, or other act transferring an interest in or ownership in a one-to-four family residential property that is insured by an owner's title insurance policy and every mortgage encumbering such immovable property that is insured by a loan title insurance policy shall contain all of the following identifying information:

(1) The name, address, and Louisiana license number of the issuing title insurance producer.

(2) The name of the title insurance underwriter issuing the policy.

(3) The name and bar roll number of the attorney licensed to practice law in Louisiana who provided the title opinion upon which the title insurance policy is based.

B. Prior to recordation, the title insurance producer shall verify that the identifying information required by Subsection A of this Section is included within the document. The information may be typed or stamped on the document or included on a separate form attached to the document.

C. The inclusion of the information on the recorded document or attachment shall not create additional liability for those named therein nor shall it create a separate cause of action against the title insurance producer, title insurance underwriter, lender, or examining attorney.

D. Failure to include the information required by this Section on any document or act shall not nullify or otherwise affect the validity of the document or act.

Added by Acts 2011, No. 164, § 1, eff. Jan. 1, 2012.

§ 514. Authorized activities; title insurers

Subject to the exceptions and restrictions contained in this Subpart, 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.

Renumbered from R.S. 22:2092.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999.

§ 515. 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 producer:

(a) Theft or misappropriation of settlement funds.

(b) Failure to comply with instructions when agreed to by the settlement agent, employee, or title insurance producer.

(2) The premium charged by a title insurer for this coverage shall be submitted to and approved by the commissioner of insurance.

(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.

Renumbered from R.S. 22:2092.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff.

June 9, 1999; Acts 2009, No. 503, § 1.

§ 516. Title insurer; establishment of rates

A. A title insurer who adopts a rating organization's rate filing made and approved pursuant to R.S. 22:1466 or files a deviation to such filing which is approved pursuant to R.S. 22:1468 shall not have its rates deemed to be excessive, inadequate, or unfairly discriminatory.

B. Notwithstanding any provision of law to the contrary, title insurers and title insurance rating organizations shall not be required to file with the commissioner of insurance or any other entity individual loss or expense information for any purpose associated with ratemaking other than statistical reporting associated with a statistical plan. Notwithstanding the foregoing, nothing in this Section shall be construed to constrain access to the books and records of any title insurer doing business in the state of Louisiana by the commissioner of the Department of Insurance.

Renumbered from R.S. 22:2092.5.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 828, § 1. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 517. Title insurance producers; licensing and reporting requirements

Every title insurance producer 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.

Renumbered from R.S. 22:2092.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 518. Title insurance producers; errors and omissions requirements

A. Every title insurance producer licensed in this state shall maintain an errors and omissions policy, which includes coverage for their acts or omissions as a title insurance producer, 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 producer shall furnish the title insurer with proof that the producer complies with this Section.

Renumbered from R.S. 22:2092.6.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 519. Title insurance producers; 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 producer

its successor in interest, transferee, or receiver as provided under this Subpart.

Renumbered from R.S. 22:2092.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 520. Underwriting contracts required; title insurer, producer

A. No person acting in the capacity of a title insurance producer shall place business with a title insurer, and no title insurer shall accept business from a title insurance producer, 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 producer.

(8) Policies and funds remittance.

(9) Termination provisions.

B. The contract shall not be assigned in whole or in part by the title insurance producer without the express written consent of the title insurer.

Renumbered from R.S. 22:2092.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 521. Title insurance producer; policies and funds remittance

A. Unless a later date is specifically authorized by the title insurer for a particular transaction, the title insurance producer 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 producer 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 producer shall issue a title insurance report wherein the issuance of a policy of insurance is not contemplated.

Renumbered from R.S. 22:2092.8.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 522. Title insurance producer; termination

A. The title insurer may terminate the contract upon written notice to the title insurance producer 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 producer, or the commencement of legal proceedings by the state of the domicile of the producer, which if successful, would lead to the cancellation of the permit or license to do business of the producer.

(2) Material breach of any provision of the contract between the title insurer and the title insurance producer.

(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 producer shall immediately discontinue all title insurance business on behalf of that title insurer.

C. Nothing in this Subsection shall relieve the title insurance producer or title insurer of any other contractual obligation.

Renumbered from R.S. 22:2092.8.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 523. Title insurance producer; claims

It shall be the duty of the title insurance producer to immediately report and forward to the title insurer all claims reported to the producer by policyholders or other persons.

Renumbered from R.S. 22:2092.8.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 524. Title insurance producer; restrictions

The title insurance producer 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 producer 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. 22:691 through 713.

(3) Jointly employ an individual who is employed with the title insurer unless the title insurer and the title insurance producer are affiliated or otherwise under common control as defined by R.S. 22:692(3)[1].

Renumbered from R.S. 22:2092.8.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 525. Title insurance producer; inventory maintenance

The title insurance producer shall maintain an inventory of all numbered policy forms or policy numbers assigned to the producer by the title insurer.

Renumbered from R.S. 22:2092.8.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 526. 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 producer. If the title insurance producer 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 insurance producer.

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.

Renumbered from R.S. 22:2092.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 527. Title insurer; agency appointment and termination

Within five days of executing or terminating a contract with a title insurance producer, 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 producer shall be made on a form

promulgated by the department.

Renumbered from R.S. 22:2092.9.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 528. Title insurer; restrictions

A title insurer shall not:

(1) Appoint any director, officer, controlling shareholder, or employee of a title insurance producer to serve on the title insurer's board of directors if the title insurance producer 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. 22:691 through 713.

(2) Jointly employ an individual who is employed with the title insurance producer unless the title insurer and the title insurance producer are affiliated or otherwise under common control as defined by R.S. 22:692(3)[1].

(3) Engage in the practice of law as defined by R.S. 37:212.

Renumbered from R.S. 22:2092.9.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 529. Title insurer; inventory maintenance

The title insurer shall maintain an inventory of all numbered policy forms or policy numbers allocated to each title insurance producer.

Renumbered from R.S. 22:2092.9.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 530. Title insurer; agency licensing and errors and omissions insurance requirements

The title insurer shall have on file evidence that each appointed title insurance producer is licensed by the state and maintains the errors and omissions insurance required by this Subpart.

Renumbered from R.S. 22:2092.9.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 192, § 1, eff. June 9, 1999. Amended by Acts 2009, No. 503, § 1.

§ 531. Policyholder rights and disclosure

A. A title insurer or a title insurance producer 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.

Renumbered from R.S. 22:2092.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 532. Maintenance, conditions; escrow, closing, or settlement services, deposit accounts by title insurer or its producer

A. A title insurer or a title insurance producer 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 producer 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 producer 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 producer 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 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 producer; 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 producer or the depository of the insurer or producer.

(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 producer.

(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 producers when the title insurance producer 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. 22:512(6).

(ii) That the funds disbursed are from those funds received by the title insurance producer at the time of the real estate closing and settlement and were in one of the forms enumerated in Paragraph (3) of this Subsection.

C. Repealed by Acts 1999, No. 192, § 2, eff. June 9, 1999.

D. Nothing in this Subpart 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 Subpart or of the laws of this state or the United States regarding the duties and obligations of an escrow agent.

Renumbered from R.S. 22:2092.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 533. Record retention; requirements

The title insurer and the title insurance producer 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.

Renumbered from R.S. 22:2092.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 2009, No. 503, § 1.

§ 534. Louisiana Insurance Code; applicability to title insurers, title insurance producers

All title insurers and title insurance producers shall be subject to all other applicable provisions of this Title unless specifically exempted by this Subpart.

Renumbered from R.S. 22:2092.13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999; Acts 2009, No. 503, § 1.

§ 535. Rules and regulations; promulgated by department

The department shall issue rules, regulations, and directives, in accordance with the Administrative Procedure Act[1] to implement the provisions of this Subpart.

Renumbered from R.S. 22:2092.14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 1999, No. 192, § 1, eff. June 9, 1999.

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

§ 536. Penalties; liabilities

A. If the department determines that the title insurer or the title insurance producer or any other person has violated this Subpart, or any rule, regulation, or order promulgated thereunder, the department, pursuant to R.S. 22:2191 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 producer 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. 22:73 and 96, Subpart H of Part III of this Chapter, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq., and the receiver appointed under that order determines that the title insurance producer or any other person has not complied with this Subpart, 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 this Title.

D. Nothing contained in this Subpart 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 producer.

Renumbered from R.S. 22:2092.15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1. Amended by Acts 2009, No. 503, § 1.

§ 537. Limits of scope

Nothing contained in this Subpart shall be deemed to amend, supersede, or repeal any provision of R.S. 37:212 and 213.

Renumbered from R.S. 22:2092.16 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1427, § 1.

SUBPART S. CAPTIVE INSURERS

Redesignation—Acts 2009, No. 503

This Subpart S of Part I of Chapter 2 of Title 22, consisting of R.S. 22:550.1 to 22:550.26, was redesignated from Chapter 19 of Title 22, consisting of R.S. 22:2411 to 22:2436, pursuant to § 3 of Acts 2009, No. 503 and the statutory revision authority of the Louisiana State Law Institute.

§ 550.1. Purpose and short title

The purpose of this Chapter is to regulate the formation and operation of domestic captive insurance companies within the state of Louisiana and may be cited as the "Captive Insurers Law."

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2411 by Acts 2009, No. 503, § 3.

§ 550.2. Definitions

As used in this Chapter, unless the context otherwise requires, the words and terms shall have the following meanings:

(1) "Affiliated company" means a company in the same corporate system as its parent or a member organization by virtue of common ownership, control, operation or management.

(2) "Association" means a legal entity consisting of two or more corporations, partnerships, associations or other forms of business organizations that are engaged in businesses or activities similar or related to a common business, trade, product, services, premises or operations.

(3) "Association captive insurer" means any company that insures only the risks of the member organizations of the association, affiliated companies of the member organizations, and the risks of the association itself.

(4) "Captive insurer" means any pure captive insurer or association captive insurer formed or licensed under the provisions of this Chapter.

(5) "Cash equivalents" means any short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value due to changes in interest rates.

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

(7) "Common ownership and control" means the direct or indirect ownership of fifty-one percent or more of the outstanding voting stock of two or more corporations by the same member or members.

(8) "Department" means the Department of Insurance.

(9) "Excess workers' compensation insurance" means insurance in excess of the specified per-incident or aggregate limit, if any, established by:

(a) The commissioner, if the insurance is being transacted in this state; or

(b) The chief regulatory officer for insurance in the state in which the insurance is being transacted.

(10) "Hazardous financial condition" means that, based upon its present or reasonably anticipated financial condition, a captive insurer, 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.

(11) "Member organization" means any corporation, partnership, association or other form of business organization that belongs to an association. Political subdivisions, as defined in Section 44 of Article VI of the Constitution of Louisiana, shall not be eligible for membership in an association.

(12) "Parent" means a corporation, limited liability company, partnership, association or other form of business organization that directly or indirectly owns, controls or holds with power to vote more than fifty-one percent of the outstanding voting securities of a captive insurer organized as a stock corporation.

(13) "Pure captive insurer" means a captive insurer that insures only the risks of its parent and affiliated companies.

(14) "Stock insurer" shall mean an incorporated insurer with issued and outstanding stock whose capital and surplus is owned by its stockholders.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2412 by Acts 2009, No. 503, § 3.

§ 550.3. Applicability of other provisions

A. The terms and conditions set forth in R.S. 22:96, Subpart H of Part III of Chapter 2 of this Title, and in Chapter 9 of this Title pertaining to rehabilitation, liquidation, conservation, dissolution and administrative supervision, apply to captive insurers licensed pursuant to this Chapter.

B. The provisions of R.S. 22:72 regarding conversions apply to captive insurers licensed pursuant to this Chapter.

C. The provisions of acquisition of control or merger with a domestic insurer of Subpart G of Part III of Chapter 2 of this Title shall apply to captive insurers licensed pursuant to this Chapter.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2413 by Acts 2009, No. 503, § 3. Amended by Acts 2012, No. 633, § 1.

§ 550.4. Regulations

The commissioner may establish such rules and regulations as are necessary to carry out the provisions of this Chapter.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2414 by Acts 2009, No. 503, § 3.

§ 550.5. Incorporation of a captive insurer

A. Unless otherwise approved by the commissioner, a pure captive insurer or an association captive insurer must be incorporated as a stock insurer pursuant to Subpart A of Part I of Chapter 2 of this Title.

B. The articles of incorporation shall be prepared, approved and recorded in the same manner as provided in Subpart A of Part I of Chapter 2 of this Title. In determining whether to grant such approval, the commissioner shall consider all of the following:

(1) The character, reputation, financial standing and purposes of the incorporators or organizers.

(2) The character, reputation, financial responsibility, experience relating to insurance and business qualifications of the officers and directors of the captive insurer.

(3) The competence of any person who, pursuant to a contract with the captive insurer, will manage the affairs of the captive insurer.

(4) The competence, reputation and experience of the legal counsel of the captive insurer relating to the regulation of insurance.

(5) The business plan of the captive insurer.

(6) Such other aspects of the captive insurer as the commissioner deems advisable.

C. The articles of incorporation or bylaws of a captive insurer must require that a quorum of the board of directors consists of not less than one-half of the number of directors prescribed by the articles of incorporation or bylaws.

D. The capital stock of a captive insurer shall be issued at not less than par value.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2415 by Acts 2009, No. 503, § 3.

§ 550.6. Certificate of authority required to transact insurance

A captive insurer shall not transact the business of insurance in this state unless the captive insurer first obtains a certificate of authority from the commissioner.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2416 by Acts 2009, No. 503, § 3.

§ 550.7. Application requirements

A. After incorporation a captive insurer shall apply to the commissioner for a certificate of authority. The application shall be certified by the initial board of directors of the captive insurer and must be accompanied by the fee as set forth in R.S. 22:821. The application shall include all of the following:

(1) A copy of the by-laws of the applicant.

(2) A financial statement for the captive insurer that has been certified by two principal officers.

(3) Biographical background information, on a form prescribed by the commissioner for each person who controls, directly or indirectly, ten percent or more of the captive insurer and for each director and officer of the captive insurer.

(4) A plan of operation which clearly indicates the method of operation of the insurer including all of the following items:

(a) The types and limits of insurance that will be provided.

(b) Pro forma financial statements for a period covering three years, which shall include a balance sheet, income statement, and cash flow statement.

(c) The amount and liquidity of its assets relative to the risks to be assumed by the captive insurer.

(d) The expertise, experience and character of the persons who will manage the captive insurer.

(e) A description of the captive insurer's reinsurance program.

(f) A description of the captive insurer's underwriting policy, including who will perform such functions.

(g) A description of the captive insurer's claims handling procedures, including who will perform such functions.

(h) A description of the captive insurer's investment policy.

(i) The overall soundness of the plan of operation of the captive insurer.

(j) The adequacy of the programs of the captive insurer providing for loss prevention by its parent or member organizations.

(k) A description of the captive insurer's rate making policies and procedures.

(5) A feasibility study, or other analysis, prepared by a qualified actuary.

(6) A statement disclosing the identity and percentage of ownership of the captive insurer for all persons who control, directly or indirectly, ten percent or more of the captive insurer.

(7) Any other information deemed to be relevant by the commissioner in ascertaining whether the proposed captive insurer will be able to meet its policy

obligations.

B. Information submitted pursuant to this Section shall be and remain confidential, and may not be made public by the commissioner or an employee or agent of the commissioner without the written consent of the captive insurer, except that:

(1) Such information may be discoverable by a party in a civil action or contested case to which the captive insurer that submitted such information is a party, upon a showing by the party seeking to discover such information that:

(a) The information sought is relevant to and necessary for the furtherance of such action or case;

(b) The information sought is unavailable from other nonconfidential sources; and

(c) A subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the commissioner.

(2) The commissioner may, in his discretion, disclose such information to a public officer having jurisdiction over the regulation of insurance in another state, provided that:

(a) Such public official agrees in writing to maintain the confidentiality of such information; and

(b) The laws of the state in which such public official serves require the information to be, and to remain, confidential.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2417 by Acts 2009, No. 503, § 3.

§ 550.8. Initial examination and issuance of certificate of authority

Upon receipt of the application for certificate of authority, the commissioner shall cause an initial examination to be made of the captive insurer. If, in the opinion of the commissioner, 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.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2418 by Acts 2009, No. 503, § 3.

§ 550.9. Change of information submitted with application

A captive insurer shall notify the commissioner of any changes to the plan of operation or other information submitted with the application within thirty days of the adoption of such change.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2419 by Acts 2009, No. 503, § 3.

§ 550.10. Capital and surplus requirements

A. A pure captive insurer shall maintain at all times, in addition to any other capital or surplus required to be maintained pursuant to Subsection D of this Section, unimpaired paid-in capital and surplus of not less than five hundred thousand dollars.

B. An association captive insurer shall maintain at all times, in addition to any other capital or surplus required to be maintained pursuant to Subsection D of this Section, unimpaired paid-in capital and surplus of not less than one million dollars.

C. Except as otherwise provided by the commissioner pursuant to Subsection D of this Section, the capital required to be maintained pursuant to this Section must be in the form of cash, cash equivalents, or bonds or evidences of indebtedness which are direct general obligations of the government of the United States.

D. The commissioner may prescribe additional requirements relating to capital and surplus based on the type, volume and nature of the insurance business that is transacted by the captive insurer.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2420 by Acts 2009, No. 503, § 3. Amended by Acts 2012, No. 633, § 1.

§ 550.11. Deposit required of association captive insurers

All association captive insurers shall, before receiving a certificate of authority, deposit with the commissioner 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 association captive 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. All securities deposited pursuant to this Section shall be held in trust for the benefit and protection of and as security for all policyholders of the association captive insurer making such deposit.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2421 by Acts 2009, No. 503, § 3.

§ 550.12. Suspension or revocation of certificate of authority; hearings

A. The commissioner may refuse, suspend or revoke the certificate of authority of a captive insurer if, after an examination and hearing, the commissioner determines that the captive insurer satisfies any one of the following items:

(1) Is insolvent or has impaired its required capital or surplus.

(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) Has failed to meet a requirement of R.S. 22:550.10.

(4) Has refused or failed to submit an annual report, as required by R.S. 22:550.21, or any other report or statement required by law or by order of the

commissioner.

(5) Has failed to comply with the provisions of its charter or bylaws.

(6) Has failed to submit to an examination, or has refused or failed to pay the cost of an examination required pursuant to R.S. 22:550.22.

(7) Has used any method in transacting the business of insurance pursuant to this Chapter which is detrimental to the operation of the captive insurer or would make its condition unsound with respect to its policyholders or the general public.

(8) Has failed otherwise to comply with the laws of this state.

(9) The suspension or revocation of the certificate of authority of the captive insurer is in the best interest of its policyholders or the general public.

B. No captive 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 captive insurer is otherwise fully qualified.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Amended by Acts 2009, No. 317, § 1. Redesignated from R.S. 22:2422 by Acts 2009, No. 503, § 3. Amended by Acts 2012, No. 633, § 1.

§ 550.13. Authorized and prohibited types of insurance

A. Except as otherwise provided in this Section, a captive insurer licensed pursuant to this Chapter may transact any form of insurance classified in R.S. 22:47.

B. A captive insurer licensed pursuant to this Chapter shall comply with the following:

(1) The insurer shall not directly provide insurance classified as life, health and accident, title, credit life, health, and accident, credit property and casualty, or annuity, as described in R.S. 22:47.

(2) The insurer shall not directly provide personal motor vehicle, homeowners' insurance coverage, or any other noncommercial line of coverage.

(3) The insurer shall not directly provide workers' compensation or employers' liability insurance coverage, except in connection with a self-funded insurance program as prescribed in this Section.

(4) The insurer shall not accept or cede reinsurance, except as otherwise provided in R.S. 22:550.17.

(5) The insurer may provide excess workers' compensation insurance to its parent

and affiliated companies, unless otherwise prohibited by the laws of the state in which the insurance is transacted.

(6) The insurer may reinsure workers' compensation insurance provided pursuant to a program of self-funded insurance of its parent and affiliated companies if either one of the following applies:

(a) The parent or affiliated company which is providing the self-funded insurance is certified as a self-insured employer by the Louisiana Workforce Commission, if the insurance is being transacted in this state.

(b) The program of self-funded insurance is otherwise qualified pursuant to, or in compliance with, the laws of the state in which the insurance is transacted.

C. A pure captive insurer shall not insure any risks other than those of its parent and affiliated companies or controlled unaffiliated businesses.

D. An association captive insurer shall not insure any risks other than those of the member organizations of its association and the affiliated companies of the member organizations.

E. An association captive insurer shall not expose itself to loss on any one risk in an amount which exceeds ten percent of the captive 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 the Section.

F. An association captive insurer shall maintain a ratio of actual annual premiums written, net of reinsurance, to current capital and surplus less than or equal to four to one.

G. Notwithstanding the provisions of this Section, a captive insurer may be licensed to provide coverage for unrelated risks if the commissioner deems that extraordinary circumstances exist which make the provision of this coverage by a captive insurer appropriate and in the best interest of the public. In determining whether such extraordinary circumstances exist, the commissioner shall consider all of the following factors:

(1) The extent to which the particular coverage is available in the voluntary market.

(2) The existence of a relationship between the parent of the captive insurer and the proposed policyholders other than that of insurer to insured.

(3) Whether the captive insurer has sufficient capital and surplus to insure the proposed risks.

(4) Any other factors which the commissioner deems appropriate.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2423 by Acts 2009, No. 503, § 3. Amended by Acts 2012, No. 633, § 1.

§ 550.14. Meetings of board of directors; additional requirements to transact insurance

A. The board of directors of a captive insurer shall meet at least quarterly each year.

B. The captive insurer shall maintain its principal place of business in this state, maintain its books and records in accordance with R.S. 22:68, and shall deliver to the commissioner an instrument authorizing service of process.

C. Prior to transacting insurance in this state, a captive insurer shall comply with all of the following items:

(1) Make adequate arrangements with a bank located in this state that is authorized pursuant to state or federal law to transfer money.

(2) Employ or enter into a contract with a natural person or business organization to manage the affairs of the captive insurer that meets the standards of competence and experience satisfactory to the commissioner.

(3) Employ or enter into a contract with a qualified and experienced certified public accountant that is approved by the commissioner or a firm of certified public accountants that is nationally recognized.

(4) Employ or enter into a contract with qualified, experienced actuaries who are approved by the commissioner to perform reviews and evaluations of the operations of the captive insurer.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2424 by Acts 2009, No. 503, § 3.

§ 550.15. Payment of dividends

A captive insurer shall not pay dividends out of, or make any other distribution with respect to, its capital or surplus, or both unless the captive insurer has obtained the prior approval of the commissioner to make such a payment or distribution.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2425 by Acts 2009, No. 503, § 3.

§ 550.16. Investments; loan to parent or affiliated company in certain circumstances

A. Except as otherwise provided in this Section, an association captive insurer shall comply with the requirements relating to investments set forth in Subpart B of Part III of Chapter 2 of this Title.

B. A pure captive insurer is not subject to any restrictions on allowable investments, except that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of the pure captive insurer.

C. A pure captive insurer may make a loan to its parent or affiliated company if the loan meets each of the following requirements:

(1) The loan is first approved in writing by the commissioner.

(2) The loan is evidenced by a note that is in a form approved by the commissioner.

(3) The loan does not include any money that has been set aside as capital or surplus as required by R.S. 22:550.10.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2426 by Acts 2009, No. 503, § 3. Amended by Acts 2012, No. 633, § 1.

§ 550.17. Reinsurance; credit for reserves on risks or portions of risks in certain circumstances; plan for workers' compensation deemed reinsurance in certain circumstances

A. No captive insurer may provide reinsurance on risks ceded by any other insurer without prior written approval of the commissioner.

B. A captive insurer may take credit for reserves on risks or portions of risks ceded to a reinsurer that is in compliance with Subpart E of Part III of Chapter 2 of this Title.

C. Subject to the approval of the commissioner, a captive insurer may take credit for reserves on risks or portions of risks ceded to a reinsurer, or to a pool, an exchange, or an association acting as a reinsurer, that does not comply with the requirements of Subsection B of this Section. The commissioner may require such documents, financial information or other evidence as he determines necessary to show that such reinsurer, pool, exchange, or association will be able to provide adequate security for its financial obligations. The commissioner may deny authorization or impose any limitations on the activities of such reinsurer, pool, exchange, or association that, in his judgment, are necessary and proper to provide adequate security for the ceding captive insurer and for the protection and benefit of the general public.

D. For the purposes of this Chapter, insurance provided by a captive insurer of any plan for workers' compensation of its parent and affiliated companies which is certified or otherwise qualified in the state in which the insurance is provided as a self-insurance plan shall be deemed to be reinsurance.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2427 by Acts 2009, No. 503, § 3. Amended by Acts 2013, No. 23, § 1, eff. May 23, 2013.

§ 550.18. Captive insurer prohibited from joining or contributing to risk-sharing plan, risk pool or insurance insolvency guaranty fund

A. A captive insurer shall not join or contribute financially to any risk-sharing plan, risk pool or insurance insolvency guaranty fund in this state. A captive insurer or its insured, its parent or an affiliated company, or any member organization of its association shall not receive any benefit from such a plan, pool or fund for claims arising out of the operations of the captive insurer.

B. Any policy issued by an association captive insurer shall contain in at least twelve-point boldface capital letters on the front page and the declaration page, the following notice:

"NOTICE

THIS POLICY IS ISSUED BY A CAPTIVE INSURER. YOUR CAPTIVE INSURER 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 CAPTIVE INSURER."

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2428 by Acts 2009, No. 503, § 3.

§ 550.19. Prohibited acts regarding solicitation or sale

The following acts by a captive insurer are hereby prohibited:

(1) The solicitation or sale of insurance by an association captive insurer to any person who is not eligible for membership in such association.

(2) The solicitation or sale of insurance by, or operation of, a captive insurer that is in a hazardous financial condition or is financially impaired.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2429 by Acts 2009, No. 503, § 3.

§ 550.20. Prohibition on ownership by an insurance company

No captive insurer shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such captive insurer, other than in the case of a captive insurer all of whose members are insurance companies.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2430 by Acts 2009, No. 503, § 3.

§ 550.21. Annual report of financial condition to commissioner; regulations designating form; alternative date to file annual report

Every captive insurer licensed in this state shall file each of the following with the department:

(1) Annually on or before March first, a statement of its financial condition for the year ending December thirty-first immediately preceding, and any amendment to the plan of operation at last year-end, verified by the oath of at least two of its executive officers. The statement shall be in the form prescribed by the commissioner.

(2) Annually on or before June thirtieth, an audited statement of the captive insurer's financial condition prepared in accordance with generally accepted accounting principles in the United States for the year ending December thirty-first immediately preceding, which shall include all of the following:

(a) Report of independent certified public accountant.

(b) Balance sheet.

(c) Income statement.

(d) Statement of cash flows.

(e) Statement of changes in capital and surplus.

(f) Notes to financial statements.

(g) Report of evaluation of internal controls.

(h) Accountant's letter.

(3) An annual actuarial certification of loss reserves and loss expense reserves which includes an opinion of the adequacy of the loss reserves and loss expense reserves of the captive insurer, in a format acceptable to the commissioner. The person that certifies the reserves must be approved by the commissioner and must be a Fellow of the Casualty Actuarial Society, and a member in good standing of the American Academy of Actuaries.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2431 by Acts 2009, No. 503, § 3.

§ 550.22. Examination by commissioner

The commissioner shall cause an examination of each captive insurer under the provisions of Chapter 8 of this Title.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2432 by Acts 2009, No. 503, § 3.

§ 550.23. Taxes on premiums and assessments

A captive insurer shall be subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to domestic insurers under Chapter 8 of this Title. A captive insurer shall be subject to assessments of the Louisiana Citizens Property Insurance Corporation under Part I of Chapter 15 of this Title.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2433 by Acts 2009, No. 503, § 3.

§ 550.24. Rates

Each association captive insurer shall file rates on an actuarially justified basis with the department and may use the rates forty-five days after filing, unless the department disapproves the use of rates within the forty-five day period.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2434 by Acts 2009, No. 503, § 3.

§ 550.25. Policy forms

A. No policy form shall be issued, delivered or used by an association captive insurer unless it has been filed with and approved by the commissioner.

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 forty-five 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.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2435 by Acts 2009, No. 503, § 3.

§ 550.26. Conflict of interest

Each captive insurer shall adopt a conflict of interest policy whereby officers, directors and key personnel annually file a conflict of interest disclosure statement with the Board of Directors.

Added by Acts 2008, No. 403, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2436 by Acts 2009, No. 503, § 3.

PART II. BUSINESS TRANSACTED WITH PRODUCER CONTROLLED INSURER LAW

§ 551. Title

This Part shall be known and may be cited as the "Business Transacted with Producer Controlled Insurer Law".

Renumbered from R.S. 22:1210.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 503, § 1.

§ 552. 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) "Control" or "controlled" has the meaning as defined in R.S. 22:692(3)[1].

(3) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

(4) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(5) "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. 22:481 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.

(6) "Producer" means an insurance producer as defined in R.S. 22:1542.

Renumbered from R.S. 22:1210.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 503, § 1.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 553. Applicability

This Part shall apply to licensed insurers as defined in R.S. 22:552, 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, R.S. 22:691 et seq., 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.

Renumbered from R.S. 22:1210.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 503, § 1.

§ 554. 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 producer 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 producer 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 producer accepts insurance placements only from nonaffiliated producers, 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 producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

B. Required contract provisions. A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer, unless there is a written contract between the controlling producer 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 producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling producer 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 producer.

(3) The controlling producer 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 producer 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 this Code. However, the funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the domiciliary jurisdiction of the controlling producer.

(5) The controlling producer 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 producer.

(7) The controlled insurer shall provide the controlling producer 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 producer 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 producer other than the controlling producer.

(8) The contract shall specify the rates and terms of the commissions, charges,

and other fees of the controlling producer 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 producers other than controlling producers. 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 producer, 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 producer 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 producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer 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 producer may negotiate, but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer 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 producer.

(2) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the controlling producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid

to noncontrolling producers for placements of the same kinds of insurance.

E. Repealed by Acts 2009, No. 503, § 2.

Renumbered from R.S. 22:1210.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 503, § 1.

§ 555. Disclosure

The controlling producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the controlling producer and the controlled insurer; except that, if the business is placed through another producer, who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the other producer that such producer is aware of the relationship between the insurer and the controlling producer and that such producer has or will notify the insured.

Renumbered from R.S. 22:1210.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 503, § 1.

§ 556. Penalties

A. If the commissioner believes that the controlling producer, 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 producer to cease placing business with the controlled insurer.

B. If it is found that, because the controlling producer 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 producer 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 this 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.

Renumbered from R.S. 22:1210.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 503, § 1.

PART III. FINANCIAL SOLVENCY AND REPORTING REQUIREMENTS

SUBPART A. FINANCIAL REPORTING REQUIREMENTS

§ 571. 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 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 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 electronically with the National Association of Insurance Commissioners. 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.

B. The annual statement shall be due before the first day of March and show the condition of the company as of the preceding thirty-first day of December. The first quarterly report shall be due prior to May fifteenth and show the condition of the company as of the preceding thirty-first day of March. The second quarterly report shall be due prior to August fifteenth and show the condition of the company as of the preceding thirtieth day of June. The third quarterly report shall be due prior to November fifteenth and show the condition of the company as of the preceding thirtieth day of September.

C. Upon the request of an insurer, the commissioner of insurance shall 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. 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.

F. 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.

G. 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.

H. 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.

I. Upon written application and approval by the commissioner, a domestic company may be exempted from the following filings required by this Section:

(1) Quarterly statements.

(2) Management discussion and analysis accompanying the annual statement.

(3) Electronic filings with the National Association of Insurance Commissioners.

(4) Holding company registration.

Renumbered from R.S. 22:1451 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by 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; Acts 2008, No. 471, § 1; Acts 2009, No. 503, § 1.

§ 572. Written catastrophe response plans

Every insurer writing any form of commercial or residential property insurance, automobile insurance, marine, or inland marine insurance or writing life or health and accident insurance shall maintain a written catastrophe response plan or plan that describes how the insurer will respond to a catastrophe affecting its policyholders. Additionally, each health maintenance organization, managing general agent, and third-party administrator shall maintain a written catastrophe response plan or plan that describes how it will respond to a catastrophe affecting its business operations. During an examination required by R.S. 22:1981, or at such other time as the commissioner deems appropriate, he shall review the written catastrophe response plan of each insurer, health maintenance organization, managing general agent, and third-party administrator, the insurance written, and the response plan most appropriate for the type of insureds or business operations at issue. The written catastrophe response plan of each insurer, health maintenance organization, managing general agent, and third-party administrator shall be deemed to be confidential, proprietary information subject to the protections of the Uniform Trade Secrets Act, pursuant to Chapter 13-A of Title 51 of the Louisiana Revised Statutes of 1950, shall not be subject to the public records disclosures of R.S. 44:1, and shall not be made public by the commissioner.

Renumbered from R.S. 22:1469 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 949, § 1, eff. July 24, 1991. Amended by Acts 2009, No. 503, § 1.

§ 572.1. Insurance anti-fraud plan

A. Each authorized insurer, other than a "small company" as defined in R.S. 22:46, and each health maintenance organization licensed to operate in this state shall prepare, implement, maintain, and file with the commissioner an insurance anti-fraud plan for its operations in this state.

B. The insurance anti-fraud plan required by Subsection A of this Section shall outline specific procedures, actions, and safeguards that include how the authorized insurer or health maintenance organization will do each of the following:

(1) Detect, investigate, and prevent all forms of insurance fraud, including fraud involving its employees or agents; fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies; fraudulent claims; and breach of security of its data processing systems.

(2) Educate employees on fraud detection and the insurance anti-fraud plan.

(3) Provide for fraud investigations, whether through the use of internal fraud investigators or third-party contractors.

(4) Report a suspected fraudulent insurance act, as defined by R.S. 22:1923(2), to the Department of Insurance as well as law enforcement and other regulatory authorities engaged in the investigation and prosecution of insurance fraud.

(5) Pursue restitution for financial loss caused by insurance fraud.

C. The commissioner shall review the insurance anti-fraud plan submitted pursuant to Subsection A of this Section to determine compliance with the requirements of this Section.

D. The commissioner may investigate and examine the records and operations of authorized insurers and health maintenance organizations to determine if they have implemented and complied with the insurance anti-fraud plan.

E. The commissioner may direct any modification to the insurance anti-fraud plan necessary to comply with the requirements of this Section, and the commissioner may require action to remedy substantial noncompliance with the insurance anti-fraud plan.

F. The insurance anti-fraud plan and any summary report shall be filed with the commissioner on or before April first of each calendar year. Either on a calendar year basis or such other interval the commissioner deems appropriate, the commissioner may require that each authorized insurer and each health maintenance organization file a summary report of any material change to the insurance anti-fraud plan, including the total number of claims and the number of claims referred to the commissioner as suspicious, and the commissioner may prescribe the format of the summary report.

G. The insurance anti-fraud plan and any summary report required by this Section are not public records and are exempt pursuant to R.S. 44:1 et seq., and specifically R.S. 44:4.1(B)(11), shall be and are hereby declared to be proprietary and confidential business records not subject to public examination

or subpoena.

Added by Acts 2010, No. 688, § 1, eff. Jan. 1, 2011. Amended by Acts 2014, No. 121, § 1.

§ 573. 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.

Renumbered from R.S. 22:1470 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 960, § 1. Amended by Acts 1992, No. 811, § 1.

§ 574. 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 Commissioners 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 this 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 Commissioners, 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.

Renumbered from R.S. 22:1451.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 503, § 1.

SUBPART B. INVESTMENTS OF DOMESTIC INSURERS

§ 581. 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 Subpart and not otherwise.

Renumbered from R.S. 22:841 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 582. General qualifications

No security or other investment shall be eligible for purchase or acquisition under this Subpart 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. 22:584 and 588. No security shall be eligible for purchase at a price above its market value.

Renumbered from R.S. 22:842 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2001, No. 61, § 1.

§ 583. 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 percent of the insurer's assets, except in the case of mortgage loans as provided in R.S. 22:584(A)(5) and in case of investments in stocks of corporations owning funeral homes as provided in R.S. 22:584(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 R.S. 22:589(A), nor include policy loans made pursuant to R.S. 22:584(E).

Renumbered from R.S. 22:843 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 584. 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, debentures issued by banks for cooperatives, collateralized mortgage obligations (CMO), bonds, and other mortgage-backed securities issued by the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Government National Mortgage Corporation, and the Vendee Mortgage Trust. Nothing in this Subpart shall prohibit the acquisition by a domestic insurer of United States government securities, the purchases of which are otherwise permitted under this Subpart in accordance with the Federal Reserve System United States Treasury Department program relating to the utilization of book entry recordkeeping 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 percent of its admitted assets in bonds or other obligations described in this Paragraph and also those described in Paragraph (13) of this Subsection.

(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 percent 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 percent 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) of this Paragraph, 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 Subpart, 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 percent 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)(a) Subject to the limit set forth in Subsection B of this Section, 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 percent of such insurer's admitted assets.

(b) Such domestic insurer shall not invest in excess of thirty-three and one-third percent 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) of this Subsection 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)(a) Subject to the limit set forth in Subsection B of this Section, 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.

(b) 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 of this Section; 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 15 U.S.C.A. § 80a-1 et seq., which men of prudence, discretion, and intelligence acquire or retain for their own account, including mutual funds that invest in foreign securities; however, no company shall invest more than five percent of its admitted assets in any one investment or an aggregate of fifty percent of admitted assets in stocks or securities described in this Paragraph. Mutual funds that invest in foreign securities shall be limited to twenty percent of admitted assets.

(13)(a) 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.

(b) No company shall invest an aggregate of more than thirty-three and one-third percent of its admitted assets in the bonds or other obligations described in Paragraph (4) of this Subsection and also those bonds described in Subparagraph (a) of this 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) Repealed by Acts 2009, No. 503, § 2.

(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 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. (1) The total investment of a domestic insurer in the securities described in Paragraphs (6) through (9), (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.

(2) The department shall have the authority to promulgate rules and regulations to further the objectives of Subsection A of this Section to establish the volatility and pricing and reporting requirements for investments authorized in

that Subsection.

C. (1)(a) Any domestic life insurer, in addition to the investment permitted by Subsection A of this Section, 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, except as specifically provided in Subparagraph (b) of this Paragraph) 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,[3] 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.

(b) Any domestic life insurer, in addition to the investment permitted by Subsection A of this Section, may invest in the stock of a real estate investment trust (REIT) whose stock is listed on the New York Stock Exchange or the American Stock Exchange, provided such investment shall not exceed five percent of the total number of shares of any one such trust and that not more than two percent of the insurer's admitted assets are invested in shares of any one such trust. Shares in each such trust which has over one-half of its assets invested in ownership of real estate or which has such ownership as its stated investment objective shall be considered real estate investment for purposes of conforming with the limitation on real estate ownership imposed by Subsection G of this Section.

(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)(i) In shares of capital stock, American Depository Receipts listed on a national securities exchange, including the National Association of Securities Dealers Automated Quotations (NASDAQ), 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 except as specifically provided in Item (ii) of this Subparagraph) 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 a national securities exchange, including NASDAQ, provided that such insurer may not, except in the case of shares permitted by Paragraph (9) of Subsection A of this Section, invest in the shares or American Depository Receipts of a corporation unless such corporation is listed on a national securities exchange, including NASDAQ, 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.

(ii) In the stock of a real estate investment trust (REIT) whose stock is listed on the New York Stock Exchange, the American Stock Exchange, or NASDAQ, provided such investment shall not exceed five percent of the total number of shares of any one such trust and that not more than two percent of its admitted assets are invested in shares of any one such trust. Shares in each such trust which has over one-half of its assets invested in ownership of real estate or which has such ownership as its stated investment objective shall be considered real estate investment for purposes of conforming with the limitation on real estate ownership imposed by Subsection G of this Section.

(b) Such insurers shall not invest more than five percent of its admitted assets in the shares of any one 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 conduct an investigation, 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 Chapter 12 of this Title, R.S. 22:2191 et seq.

(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. 22:589.

(3) An insurer may invest in, acquire debt obligations of, or otherwise acquire and hold an interest in any limited partnership, limited liability company, or master limited partnership which is formed pursuant to the laws of any state or

the United States of America and which invests in assets otherwise permitted under this Subpart. No limited partnership interest, limited liability company interest, master 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, limited liability interests, master 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 percent 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 percent of the admitted assets of such insurer on the December thirty-first next preceding such investment.

(4) Repealed by Acts 2004, No. 505, § 2.

(5) Repealed by Acts 2004, No. 505, § 2.

(6) Orders or decisions of the commissioner of insurance shall be subject to review as provided in Chapter 12 of this Title, R.S. 22:2191 et seq.

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 Subpart, 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 Subpart.

(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 admitted 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. 22:832(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. 22:832 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 admitted assets.

Renumbered from R.S. 22:844 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 112, §§ 1, 2; Acts 1958, No. 200, § 1. Amended by 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; Acts 2006, No. 414, § 1; Acts 2007, No. 294, § 1; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2010, No. 362, § 1; Acts 2012, No. 67, § 1.

[1] See, now, 38 U.S.C.A. § 3101 et seq.

[2] 12 U.S.C.A. § 1724 et seq. (repealed); see, now 12 U.S.C.A. § 1701 et seq.

[3] 15 U.S.C.A. § 78a et seq.

§ 585. 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. 9:3500 and 9:3503, 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.

Renumbered from R.S. 22:844.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 680, § 1.

§ 586. 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. A domestic 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 Subpart 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.

Renumbered from R.S. 22:844.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 61, § 1. Amended by Acts 2009, No. 503, § 1.

§ 587. Loaning of securities

A. A domestic insurer may lend securities held by it to any member of the Financial Industry Regulatory Authority having a net worth of at least one hundred million dollars, under this Subpart, 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.

Renumbered from R.S. 22:844.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 591, § 1. Amended by Acts 2003, No. 126, § 1; Acts 2010, No. 7, § 3, eff. May 19, 2010.

§ 588. 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 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) of this Subsection, shall not exceed two percent of the investing insurer's admitted assets.

(6) Such real estate as shall have been acquired in R.S. 22:584.

(7) Such as shall be held as security for contracts for deeds acquired in accordance with the provisions of R.S. 22:584(A)(5), and not in default.

(8) Such as may be acquired or held in connection with a loan or investment permitted by R.S. 22:584(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 of this Section 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.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:845 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 589. Foreign securities

A. A domestic insurer authorized to transact insurance in a foreign country may invest any of its funds, in an aggregate amount not exceeding one hundred twenty percent 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 Subpart for investments in the United States; however, 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 of this Subsection.

B. A domestic insurer may invest any of its funds, in an aggregate amount not exceeding five percent of its admitted assets, in addition to any amount permitted pursuant to Subsection 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 Subpart.

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. 22:584 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. 22:584 shall be considered to name the particular foreign country or countries in which the investments made hereunder are placed.

Renumbered from R.S. 22:846 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1977, No. 205, § 1; Acts 1983, No. 353, § 1; Acts 1997, No. 988, § 1; Acts 2009, No. 503, § 1.

§ 590. When restrictions not applicable

A. The restrictions of R.S. 22:584 and 588 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.

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. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:847 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 591. 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.

Renumbered from R.S. 22:848 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 592. 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.

Renumbered from R.S. 22:849 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 593. 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; and the amount of the loan, rate of interest, and terms of repayment.

(2) In the case of securities: the name of the obligor and a description of the security, the amount invested, the rate of interest or dividend, and 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; and the purchase price and terms.

(4) In the case of all investments:

(a) The amount of expenses estimated, if details are not available and commissions if any are 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.

Renumbered from R.S. 22:850 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 594. 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 Subpart for similar funds of like domestic insurers.

Renumbered from R.S. 22:851 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 595. Repealed by Acts 2009, No. 503, § 2

§ 596. Acquisition and holding of real property by domestic insurers in foreign countries

A. 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 percent of the company's assets in such country and must be built from funds arising from the transaction of business in such country.

B. Such property shall be considered as a foreign security within the meaning of R.S. 22:589. The investment in such property shall also be included, together with that of other real estate held under the terms of R.S. 22:588 in determining whether or not there has been compliance with the limit on investments fixed by R.S. 22:588(A)(1).

Renumbered from R.S. 22:853 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 597. 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.

Renumbered from R.S. 22:854 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 311, § 1.

§ 598. Admitted assets

For the purposes of this Subpart, the following assets, if owned by a domestic 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 Subpart 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. 22:599(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 this 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 data processing equipment as defined by the NAIC Accounting Practices and Procedures Manual.

(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.

Renumbered from R.S. 22:855 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 1993, No. 787, § 1; Acts 1995, No. 1124, § 1; Acts 1995, No. 1124, § 1; Acts 1997, No. 1449, § 1; Acts 2009, No. 503, § 1; Acts 2010, No. 339, § 1.

§ 599. Excluded assets

In addition to assets impliedly excluded by the provisions of R.S. 22:598, 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. 22:598(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 this 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) of this Paragraph 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.

Renumbered from R.S. 22:856 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 1993, No. 787, § 1; Acts 1995, No. 1124, § 1; Acts 1997, No. 1449, § 1; Acts 2009, No. 503, § 1.

§ 600. 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.

Renumbered from R.S. 22:857 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

§ 601. 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. 22:584(I) and 587.

(2) Invest only in investments which an insurer may acquire under this Subpart, 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 Subpart, 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 Subpart.

(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. 22:584 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. 22:2034.

(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. 22:704(A)(6). Investment activities of pools and transactions between pools and participants shall be reported annually in the registration statement required by R.S. 22:703.

Renumbered from R.S. 22:858 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1171, § 1. Amended by Acts 2009, No. 503, § 1.

SUBPART C. RISK BASED CAPITAL FOR DOMESTIC INSURERS

§ 611. Definitions

As used in this Subpart, 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. 22:612(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. 22:47(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. 22:47(2).

(4) "NAIC" means the National Association of Insurance Commissioners.

(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. 22:47(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 two hundred percent of a company's authorized control level risk-based capital.

(c) "Mandatory-control level risk-based capital" means seven-tenths of a company's authorized control level risk-based capital.

(d) "Regulatory-action level risk-based capital" means one hundred fifty percent of a company's authorized control level risk-based capital.

(9) "Risk-based capital plan" means a comprehensive financial plan containing the requirements of R.S. 22:613(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. 22:612.

(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 Paragraph (7) of this Section.

Renumbered from R.S. 22:860 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 503, § 1; Acts 2012, No. 359, § 1.

§ 612. 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".

Renumbered from R.S. 22:861 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 1999, No. 1304, § 1, eff. July 12, 1999; Acts 1999, No. 1312, § 1, eff. July 12, 1999.

§ 613. 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 greater than or equal to its company-action level but below three hundred percent of its authorized-control level but triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions.

(c) The property and casualty insurer maintains a total adjusted capital which is greater than or equal to its company-action level risk-based capital but below three hundred percent of its authorized-control level risk-based capital but triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions.

(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. 22:617.

(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.

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.

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.

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. 22:617.

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. 22:618(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.

Renumbered from R.S. 22:862 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2011, No. 11, § 1; Acts 2012, No. 359, § 1.

§ 614. 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. 22:617.

(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. 22:617.

(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. 22:613(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. 22:617.

(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. 22:617.

(9) If the insurer challenges a determination by the department, the notification by the department in Paragraph (8) of this Subsection 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, 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.

Renumbered from R.S. 22:863 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 317, § 1.

§ 615. 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. 22:617.

(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. 22:617.

(5) If the insurer has disputed a corrective order pursuant to R.S. 22:617 and the department has rejected the dispute 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. 22:614 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 R.S. 22:73 and 96, Subpart H of this Part, R.S. 22:731 et seq., and Chapter 9 of this Code, R.S. 22:2001 et seq.

(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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Code and to have the rights, powers, and duties with respect to the insurer as are set forth in R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Code.

Renumbered from R.S. 22:864 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 616. 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. 22:617.

(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.

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 R.S. 22:73 and 96, Subpart H of this Part, R.S. 22:731 et seq., and Chapter 9 of this Code, R.S. 22:2001 et seq. 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Code. If the department takes actions pursuant

to an adjusted risk-based capital report, the insurer shall be entitled to the protection of this 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Code. If the department takes actions pursuant to an adjusted risk-based capital report, the insurer shall be entitled to the protection of this 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.

Renumbered from R.S. 22:865 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 617. Hearings; administrative

An insurer may make written demand for an administrative hearing, pursuant to the provisions of Chapter 12 of this Title, 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.

Renumbered from R.S. 22:866 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 503, § 1.

§ 618. 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 Subpart or any other provision of this 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 Subpart, 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.

Renumbered from R.S. 22:867 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 503, § 1.

§ 619. Supplemental provisions; rules; exemption

A. The provisions of this Subpart 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 this Code.

B. The department may adopt reasonable rules and regulations necessary for the implementation of this Subpart.

C. The department may exempt from the application of this Subpart 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.

Renumbered from R.S. 22:868 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 503, § 1.

§ 620. 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 Subpart 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 Subpart, 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. 22:613, 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 this 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.

Renumbered from R.S. 22:869 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1203, § 1, eff. June 29, 1995. Amended by Acts 2009, No. 503, § 1.

SUBPART D. RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS

Change of Heading—Acts 2014, No. 220

Acts 2014, No. 220, § 1 deleted "Maintenance" preceding "Organizations" in the Subpart D heading.

§ 631. Definitions

As used in this Subpart, these terms 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. 22:632(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 Subpart I of Part I of this Chapter, a limited health service organization which bears risk, dental or vision plan which bears risk, hospital, medical and dental indemnity or service corporation which bears risk, provider-sponsored organization which bears risk, or other risk-bearing managed care organization licensed under this Title. "Health organization" shall not include an organization that is licensed as either a life, health and accident, or property and casualty insurer under this Title and that is otherwise subject to either the life or property and casualty risk-based capital requirements.

(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) "Company-action level risk-based capital" means the product of two and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(b) "Regulatory-action level risk-based capital" means the product of one and one half and the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(c) "Authorized-control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

(d) "Mandatory-control level risk-based capital" means the product of seventy hundredths 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. 22:634(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. 22:632.

(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. 22:252.

(b) Such other items, if any, as the risk-based capital instructions may provide.

Renumbered from R.S. 22:2036.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003. Amended by Acts 2009, No. 503, § 1; Acts 2014, No. 220, § 1.

§ 632. 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.

Renumbered from R.S. 22:2036.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003.

§ 633. 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.

Renumbered from R.S. 22:2036.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003.

§ 634. 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. If a health organization has 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 three, and triggers the trend test determined in accordance with the trend test calculation included in the health risk-based capital instructions.

(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. 22:638.

(3) If pursuant to R.S. 22:638, 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 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. 22:638, within forty-five days after notification to the health organization that the commissioner has 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. 22:638, within forty-five days after a notification to the health organization that the commissioner has 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. 22:638, specify in the notification that the notification constitutes a regulatory action level event.

Renumbered from R.S. 22:2036.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2014, No. 220, § 1.

§ 635. 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. 22:638.

(3) If, pursuant to R.S. 22:638, 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 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. 22:634(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. 22:638.

(7) If, pursuant to R.S. 22:638, 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 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. 22:638.

(9) If, pursuant to R.S. 22:638, 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 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. 22:638 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 rejected the health organization's challenge.

(3) If the health organization challenges a revised risk-based capital plan pursuant to R.S. 22:638 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.

Renumbered from R.S. 22:2036.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 636. 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. 22:638.

(3) If, pursuant to R.S. 22:638, 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 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. 22:638.

(5) If the health organization has challenged a corrective order pursuant to R.S. 22:638 and the commissioner has 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. 22:635 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 R.S. 22:73 and 96, Subpart H of this Part, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq. 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Title and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 of this Title.

Renumbered from R.S. 22:2036.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 637. 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. 22:638.

(3) If, pursuant to R.S. 22:638, 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 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 R.S. 22:73 and 96, Subpart H of this Part, R.S. 22:731 et seq., and Chapter 9 of this Title, R.S. 22:2001 et seq. 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 R.S. 22:73 and 96, Subpart H of this Part, and Chapter 9 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.

Renumbered from R.S. 22:2036.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 638. Hearings

Upon the occurrence of any of the following events, the health organization shall have the right to demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq. 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.

Renumbered from R.S. 22:2036.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 639. 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 Subpart 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 Subpart, 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 Subpart and the formulas, schedules, and instructions referenced in this Subpart 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 Subpart. 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 Subpart.

Renumbered from R.S. 22:2036.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003.

§ 640. Supplemental provisions; rules; exemption

A. The provisions of this Subpart 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 Subpart.

Renumbered from R.S. 22:2036.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003.

§ 641. 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 Subpart.

Renumbered from R.S. 22:2036.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 1, eff. Dec. 31, 2003.

§ 642. Notices to health maintenance organizations; effectiveness

All notices by the commissioner to a health maintenance organization that may result in regulatory action under this Subpart 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.

Renumbered from R.S. 22:2036.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1106, § 2, eff. Dec. 31, 2003.

SUBPART E. REINSURANCE

§ 651. Reinsurance credits

A. The commissioner shall allow credit for reinsurance to a domestic ceding insurer as either an asset or deduction from liability when the assuming insurer satisfies the requirements of Subsection B, C, D, E, or F of this Section. The commissioner shall allow credit under Subsection B or C of this Section pertaining only to cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. The commissioner shall allow the credit for reinsurance pursuant to Subsection D of this Section only if the assuming insurer satisfies the requirements of Subsection G of this Section.

B. The commissioner shall allow credit for reinsurance when the assuming insurer is authorized in this state. An authorized insurer is one that holds a certificate of authority to transact insurance or reinsurance.

C. The commissioner shall allow credit for reinsurance when the assuming insurer is accredited by the commissioner as a reinsurer in this state. To be eligible for accreditation and to receive the commissioner's approval of its application for accreditation, a reinsurer shall complete each of the following:

(1) File with the commissioner evidence of its submission to the jurisdiction of this state.

(2) Submit to the authority of the commissioner to examine its books and records.

(3) Demonstrate that it 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 that employs standards regarding credit for reinsurance equal to or exceeding those applicable under this Subpart.

(4) File annually with the commissioner a true copy of its annual statement filed with the insurance regulator of its state of domicile and a copy of its most recent audited financial statement.

(5) Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. The commissioner shall deem that an assuming insurer meets this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars and the commissioner has not denied it accreditation within ninety days after submission of its application.

D. (1) The commissioner shall allow a domestic ceding insurer credit for reinsurance under Paragraph (2) of this Subsection when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in R.S. 22:653(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. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination.

(2)(a) The commissioner shall not grant credit for reinsurance under this Subsection unless the form of the trust and any amendments to the trust receive the approval of either of the following:

(i) The commissioner of the state of domicile of the trust.

(ii) The commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust.

(b) The assuming insurer shall also file the form of the trust and any trust amendments with the commissioner of every domiciliary state of the ceding insurer beneficiaries of the trust. 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 its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner.

(c) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than the last day of February of each year the trustee of the

trust shall report to the commissioner in writing the balance of the trust and list the trust's investments at the preceding year-end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following thirty-first day of December.

(3)(a) In the case of a single assuming insurer, the trust fund shall consist of funds in trust 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, except as provided in Subparagraph (b) of this Paragraph.

(b) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of the United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flow, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(c) In the case of a group of assuming insurers that includes incorporated and individual unincorporated underwriters, the following provisions apply:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group.

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this Subpart, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States.

(iii) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of the United States domiciled ceding insurers or any member of the group for all years of account.

(iv) The incorporated members of the group shall not engage in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(v) Within ninety days after its financial statements are due to be filed with

the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(d) In the case of a group of incorporated underwriters under common administration, the group shall:

(i) Submit to the commissioner's authority to examine its books and records and bear the expense of any examination.

(ii) Maintain aggregate policyholders' surplus of ten billion dollars.

(iii) Maintain a trust fund 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. The commissioner shall allow credit for reinsurance when the assuming insurer is certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this Subsection.

(1) To be eligible for certification, the assuming insurer shall meet the following requirements:

(a) The assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to Paragraph (3) of this Subsection.

(b) The assuming insurer shall maintain minimum capital and surplus or its equivalent, in an amount to be determined by the commissioner, pursuant to regulation.

(c) The assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner pursuant to regulation.

(d) The assuming insurer shall agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment.

(e) The assuming insurer shall agree to meet applicable information filing

requirements as determined by the commissioner for its initial application for certification and for its continual maintenance of certification as a reinsurer.

(f) The assuming insurer shall satisfy any other requirements for certification deemed relevant by the commissioner.

(2) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. To be eligible for certification, in addition to satisfying requirements of Paragraph (1) of this Subsection:

(a) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents and net of liabilities of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection.

(b) The incorporated members of the association shall not engage in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control to which the unincorporated members are subject, pursuant to the authority of the association's domiciliary regulator.

(c) Within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or, if a certification is unavailable, the association shall provide financial statements, prepared by independent public accountants, of each underwriter member of the association.

(3) The commissioner shall create and publish a list of qualified jurisdictions.

(a) To determine the eligibility of the domiciliary jurisdiction of a non-United States assuming insurer for recognition as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and continually thereafter, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. The commissioner may not recognize a jurisdiction as a qualified jurisdiction if the commissioner determines that it does not adequately and promptly enforce final United States judgments and arbitration awards. The commissioner may consider additional factors in determining qualified jurisdictions.

(b) The commissioner shall consider the list of qualified jurisdictions published by the NAIC through the NAIC committee process in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria to be developed pursuant to regulations.

(c) The commissioner shall recognize as qualified jurisdictions those United States jurisdictions that meet the requirements for accreditation under the NAIC

financial standards and accreditation program.

(d) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(4) The commissioner shall publish a list of all certified reinsurers and their ratings assigned by the commissioner giving due consideration to the financial strength ratings assigned by rating agencies acceptable to the commissioner pursuant to regulation.

(5) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this Subsection at a level consistent with its rating, as specified in regulations promulgated by the commissioner.

(a) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with the provisions of R.S. 22:652, or in a multi-beneficiary trust in accordance with Subsection D of this Section, except as otherwise provided in this Subsection.

(b) If a certified reinsurer maintains a trust to fully secure its obligations subject to Subsection D of this Section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multi-beneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this Subsection or comparable laws of other United States jurisdictions and for its obligations subject to this Subsection. It shall be a condition to the grant of certification pursuant to this Subsection that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(c) The minimum trusteed surplus requirements provided in Subsection D of this Section are not applicable with respect to a multi-beneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred pursuant to this Subsection, except that such trust shall maintain a minimum trusteed surplus of ten million dollars.

(d) With respect to obligations incurred by a certified reinsurer pursuant to this Subsection, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(e) For purposes of this Subsection, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent of its obligations.

(i) As used in this Subsection, the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(ii) If the commissioner continues to assign a higher rating as permitted by other provisions of this Section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(6) The commissioner may certify a reinsurer in this state based on the certification and assigned rating granted to that reinsurer by another NAIC accredited jurisdiction.

(7) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this Subsection, and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

F. 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, D, or E of this Section, only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law of that jurisdiction.

G. If the assuming insurer is not authorized, accredited, or certified to transact insurance or reinsurance in this state, the commissioner shall not allow the credit permitted by Subsection D unless each of the following criteria are met:

(1)(a) The assuming insurer provides the following in all reinsurance agreements:

(i) 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.

(ii) 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.

(b) The provisions of Items (a)(i) and (ii) 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 commissioner 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 commissioner 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 take place only upon showing of good cause by the commissioner for concern about the financial soundness or solvency of the subject entity.

H. The ceding insurer may take credit for the reserves on such ceded risks to the extent reinsured, except that:

(1) The ceding insurer shall not take credit for such reserves unless the insurer accepting the reinsurance meets the requirements set forth in this Section as valid assuming insurers.

(2) The commissioner shall not allow credit 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) The commissioner shall not permit credit for reinsurance 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 that has been doing business in its country of domicile for at least three years, unless the commissioner, for good cause shown, waives this three-year operating requirement by rule or regulation.

I. If the assuming insurer does not meet the requirements of Subsection B or C of this Section, the credit permitted by Subsection D or E of this Section shall not be allowed unless the assuming insurer agrees in the trust agreements to each of the following conditions:

(1) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by Paragraph (D)(3) of this Section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(2) The commissioner with regulatory oversight, according to the laws relative to the liquidation of domestic insurance companies of the state in which the trust is domiciled, shall distribute the assets and shall value claims. Claims shall also be directed to the commissioner with the regulatory oversight as provided in this Paragraph.

(3) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(4) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

J. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(1) The commissioner shall give the reinsurer notice and opportunity for a hearing. The suspension or revocation may not take effect until after the commissioner's order upon a hearing unless one of the following circumstances are present:

(a) The reinsurer waives its right to a hearing.

(b) The commissioner's order is based upon regulatory action by the reinsurer's domiciliary jurisdiction or upon the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under Paragraph (E)(6) of this Section.

(c) The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(2) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with R.S. 22:652. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation, except to the extent that the reinsurer's obligations under the contract are secured in accordance with the provisions of Paragraph (E)(5) of this Section or in accordance with R.S. 22:652.

K. (1) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated insurers, exceeds fifty percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(2) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Renumbered from R.S. 22:941 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by 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; Acts 2009, No. 503, § 1; Acts 2012, No. 419, § 1.

§ 652. 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. 22:651 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. 22:653(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), including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the NAIC Securities Valuation Office, and qualifying as admitted assets.

(3)(a) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in R.S. 22:653(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 insurer 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.

Renumbered from R.S. 22:941.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 996, § 1, eff. Jan. 1, 1992. Amended by Acts 1995, No. 1182, § 1; Acts 2012, No. 419, § 1.

§ 653. Qualified United States financial institutions

A. Only for purposes of R.S. 22:652(3), a "qualified United States financial institution" means an institution that:

(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 Subpart 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.

Renumbered from R.S. 22:941.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 996, § 1, eff. Jan. 1, 1992. Amended by Acts 2012, No. 271, § 1.

§ 654. 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) of this Subsection, 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 Subpart B of Part IV of this Chapter, R.S. 22:761 et seq.

(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 Subpart if it were the direct insurer of such assumed risks on the basis specified in the reinsurance agreement.

Renumbered from R.S. 22:941.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 996, § 1, eff. Jan. 1, 1992. Amended by Acts 2009, No. 503, § 1.

§ 655. Unearned premium reserve; reduction below required amount prohibited

Nothing contained in R.S. 22:651 through 655 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 Subpart.

Renumbered from R.S. 22:941.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 996, § 1, eff. Jan. 1, 1992.

§ 656. 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, an aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

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.

Renumbered from R.S. 22:942 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 788, § 1; Acts 1995, No. 1182, § 1; Acts 2009, No. 317, § 1.

§ 657. 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.

Renumbered from R.S. 22:943 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1991, No. 996, § 1, eff. Jan. 1, 1992.

§ 658. 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.

Renumbered from R.S. 22:944 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 659. 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.

Renumbered from R.S. 22:945 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 660. 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.

Renumbered from R.S. 22:946 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1979, No. 316, § 1.

§ 661. Authorization

The commissioner may adopt, pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., rules and regulations to implement any provision of this Subpart.

Renumbered from R.S. 22:947 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 996, § 1, eff. Jan. 1, 1992. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

SUBPART F. AUDITED FINANCIAL REPORTING

§ 671. Title

This Subpart shall be known and may be cited as the "Audited Financial Reports Law".

Renumbered from R.S. 22:1321 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 264, § 1.

§ 672. Purpose and scope

The purpose of this Subpart is to improve the commissioner's surveillance of the financial condition of insurers by requiring an annual audit by independent certified public accountants of the financial statements reporting the financial condition and the results of operations of insurers.

Renumbered from R.S. 22:1322 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 264, § 1. Amended by Acts 1992, No. 811, § 1; Acts 1995, No. 595, § 1, eff. June 18, 1995; Acts 2009, No. 503, § 1.

§ 673. 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 required by its annual statement instruction handbook. The commissioner may determine and require that additional information be submitted in the annual financial report.

Renumbered from R.S. 22:1323 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 264, § 1. Amended by Acts 1995, No. 595, § 1, eff. June 18, 1995; Acts 2009, No. 503, § 1.

§ 674. Exemptions and filing dates

A. (1) The commissioner shall grant an exemption from the provisions of this Subpart if:

(a) After written application for an exemption submitted by an insurer, the commissioner determines that compliance with this Subpart 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 Subpart, 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 Subpart, the insurer may request, in writing, a hearing on its application for an exemption. The hearing shall be held in accordance with Chapter 12 of

this Title, R.S. 22:2191 et seq.

(4) Notwithstanding any provision to the contrary, any domestic insurer that is licensed to write business only in the state of Louisiana may make written application to the commissioner for a waiver from the requirements of this Subsection.

B. Upon written application of an insurer, the commissioner may permit an insurer to file audited 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 Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1324 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 264, § 1. Amended by Acts 1995, No. 595, § 1, eff. June 18, 1995; Acts 2008, No. 471, § 1; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

§ 675. Rules and regulations

The commissioner shall adopt reasonable rules and regulations for the implementation and administration of the provisions of this Subpart in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

Renumbered from R.S. 22:1325 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 264, § 1. Amended by Acts 1995, No. 595, § 1, eff. June 18, 1995.

SUBPART G. INSURANCE HOLDING COMPANY REQUIREMENTS [REPEALED AND REDESIGNATED]

Repeal and Redesignation—Acts 2012, No. 294

Subpart G of Part III of Chapter 2 of Title 22, consisting of R.S. 22:691 through 22:723, was repealed and redesignated by Acts 2012, No. 294. R.S. 22:695 to 22:702, formerly in this Subpart, were redesignated as R.S. 22:232.1 to 22:232.8, respectively, in existing Subpart H of of Part I of Chapter 2 of Title 22, while R.S. 22:714 to 22:720 and R.S. 22:722 and 22:723, formerly in this Subpart, were redesignated into a new Subpart G-1 of Part III of Chapter 2 of Title 22 as R.S. 22:691.19 to 22:691.27, respectively.

Sections 2 and 3 of Acts 2012, No. 294 provide:

"Section 2. Except as provided in Section 3 of this Act, Subpart G of Part III of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:691 through 723, is hereby repealed.

"Section 3. R.S. 22:695 through 702 are hereby redesignated in their entirety to R.S. 22:232.1 through 232.8."

§ 691. Repealed by Acts 2012, No. 294, § 2

SUBPART G-1. INSURANCE HOLDING COMPANY SYSTEM REGULATORY LAW

Change of heading

Pursuant to the statutory revision authority of the Louisiana State Law Institute, in 2012, "Law" was substituted for "Act" at the end of the Subpart heading.

§ 691.1. Title

This Subpart shall be known and may be cited as the "Insurance Holding Company System Regulatory Law".

Added by Acts 2012, No. 294, § 1.

§ 691.2. Definitions

As used in this Subpart, the following terms shall have these meanings unless the context shall otherwise require:

(1) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) "Commissioner" means the commissioner of insurance, the commissioner's deputies, or the Department of Insurance, as appropriate.

(3) "Control", including the terms "controlling", "controlled by", and "under common control with", 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. 22:691.4(E) and 691.6(K) that control does not exist in fact. The commissioner may determine that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including but not limited to anything that would cause the insurer's risk-based capital to fall into company action level as set forth in R.S. 22:611 et seq., and 631 et seq., or would cause the insurer to be in hazardous financial condition.

(5) An "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. 22:46(10). For the purposes of this Subpart, a health maintenance organization as defined R.S. 22:242(7) shall also be considered an insurer. The term "insurer" 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 limited liability company, 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 immovable or corporeal movable property.

(8) A "securityholder" of a specified person is 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) A "subsidiary" of a specified person is an affiliate controlled by such person directly or indirectly through one or more intermediaries.

(10) "Voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

(11) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner pursuant to R.S. 22:691.9.1 to have sufficient significant contacts with the internationally active insurance group.

(12) "Internationally active insurance group" means an insurance holding company system that:

(a) Includes an insurer registered pursuant to R.S. 22:691.6.

(b) Meets the following criteria:

(i) Premiums are written in at least three countries.

(ii) The percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums.

(iii) Based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars or the total gross written premiums of the insurance holding company system are at least ten billion dollars.

Added by Acts 2012, No. 294, § 1. Amended by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.3. Subsidiaries of insurers

A. Authorization. A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall 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 other 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 the lesser of ten percent of the insurer's assets or fifty percent of the 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 meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and each of the following 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 the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities.

(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 Paragraph (1) of this Subsection or in any other limitations specified in this Code applicable to the insurer. For the purpose of this Paragraph, "the total investment of the insurer" shall include each of the following:

(a) Any direct investment by the insurer in an asset.

(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 the 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 the 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 made

pursuant to Subsection B of this Section meets the applicable requirements of that Subsection is to be determined before the 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 the investment shall have been made, the investment shall have met the requirements for investment under any other section of this Code, and the insurer has so notified the commissioner.

Added by Acts 2012, No. 294, § 1.

§ 691.4. Acquisition of control of or merger with domestic insurer

A. Filing requirements.

(1) 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 for, 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 the 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 the offer, request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to the insurer, a statement containing the information required by this Section and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner prescribed in this Subpart.

(2) For purposes of this Section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer in any manner shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty days prior to the cessation of control. The commissioner shall determine those instances in which the person seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his discretion, determines that confidential treatment will interfere with enforcement of this Section. If the statement referred to in Paragraph (1) of this Subsection is otherwise filed, this Paragraph shall not apply.

(3) With respect to a transaction subject to this Section, the acquiring person shall also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in R.S. 22:691.5(C)(1). Failure to file the notification may subject such acquiring person to the penalties specified in R.S.

22:691.5(E)(3).

(4) For purposes of this Section, a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the commissioner, is, either directly or through its affiliates, primarily engaged in business other than the business of insurance. For the purposes of this Section, person shall not include any securities broker holding, in the usual and customary broker's 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 shall be made under oath or affirmation and shall contain a complete disclosure of 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 the "acquiring party".

(a) If the person is an individual, he shall also disclose 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 the person is not an individual, it shall include a report that discloses the following information:

(i) The nature of its business operations during the past five years or for such lesser period as such person or any predecessors thereof have been in existence.

(ii) An informative description of the business intended to be done by the person and the person's subsidiaries.

(iii) A list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by Subparagraph (a) of this Paragraph.

(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 where 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 consideration, provided however, that where a source of 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 the 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 acquiring party, or for such lesser period as the acquiring party and any predecessors shall have been in existence, 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 the 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; 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 determined.

(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. The description shall identify the persons with whom the 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.

(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 the 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 to them.

(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) An agreement by the person required to file the statement referred to in Subsection A of this Section that it will provide the annual report, specified in R.S. 22:691.6(L), for so long as control exists.

(13) An acknowledgment by the person required to file the statement referred to in Subsection A of this Section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer.

(14) 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.

C. (1) 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 (B)(1) through (14) of this Section shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in Subsection A of this Section is a corporation, the commissioner may require that the information called for by Paragraphs (B)(1) through (14) of this Section shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation.

(2) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this Section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two business days after the person learns of the change.

D. 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 the documents in furnishing the information called for by that registration statement.

E. 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, the commissioner makes any of the following findings:

(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. In applying the competitive standard mandated by this Subparagraph, the following factors shall apply:

(i) The informational requirements of R.S. 22:691.5(C)(1) and the standards of R.S. 22:691.5(D)(2).

(ii) The merger or other acquisition shall not be disapproved if the commissioner finds that any of the situations meeting the criteria provided by R.S. 22:691.5(D)(3) exist.

(iii) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time.

(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 (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 shall be given by the commissioner to the person filing the statement and to the insurer. The commissioner shall publish a notice of the hearing in a daily newspaper in each of the congressional districts of the state for at least three consecutive days. The last date of publication shall be not less than ten days prior to the date of the hearing. Such notice shall include the name of the insurer and the name of person or persons who have filed the statement pursuant to Subsection A of this Section. The commissioner shall make a determination within the thirty-day period after the conclusion of such hearing. At the 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 shall have the right to present evidence, examine, and cross examine witnesses, and offer oral and written arguments, and in connection with such hearing, 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) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in Paragraph (2) of this Subsection may be held on a consolidated basis upon request of the person filing the statement referred to in Subsection A of this Section. Such person shall file the statement referred to in Subsection A of this Section with the National Association of Insurance Commissioners (NAIC) within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten days of the receipt of the statement referred to in Subsection A of this Section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty days after the date of notification of the change in control submitted pursuant to Paragraph (A)(1) of this Section.

(5) The commissioner may retain at the acquiring person's expense, any 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.

F. Exemptions. (1) The provisions of this Section shall not apply to any offer, request, invitation, agreement, or acquisition which the commissioner, by order, shall exempt for any of the following reasons:

(a) The offer or agreement was not made or entered into for the purpose of, and did not have the effect of changing or influencing the control of a domestic insurer.

(b) The offer or agreement was not otherwise comprehended within the purposes of this Section.

(c) The change in control results from an inheritance, donation, or similar type transfer of ownership.

(2) Exemptions pursuant to Subparagraph (1)(a) or (b) this Subsection shall be requested and granted by the commissioner prior to the transaction.

(3) Notice of any change of control which results from an inheritance, donation, or similar type transfer of ownership shall be submitted to the commissioner no more than sixty days after such change in the format required by the commissioner.

G. 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 Subsection A or B of this Section.

(2) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

H. Jurisdiction; consent to service of process. The courts of 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, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the 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 violations of this Section. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at his last known address.

Added by Acts 2012, No. 294, § 1. Amended by Acts 2014, No. 791, § 8.

§ 691.5. Acquisitions involving insurers not otherwise covered

A. Definitions. The following definitions shall apply for the purposes of this Section only:

(1) "Acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers.

(2) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

B. Scope.

(1) Except as exempted in Paragraph (2) of this Subsection, this Section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

(2) This Section shall not apply to any of the following events:

(a) A purchase of securities solely for investment purposes so long as the securities are not used by voting, or otherwise, to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control pursuant to R.S. 22:691.2, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state.

(b) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commissioner in accordance with Subsection C of this Section thirty days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this Section if the acquisition would otherwise be excluded from this Section by any other Subparagraph of Subsection B of this Section.

(c) The acquisition of already affiliated persons.

(d)(i) An acquisition if, as an immediate result of the acquisition, any of the following circumstances would exist:

(aa) There is no market where the combined market share of the involved insurers would exceed five percent of the total market.

(bb) There would be no increase in any market share.

(cc) There is no market wherein the combined market share of the involved insurers would exceed twelve percent of the total market, and the market share would

increase by more than two percent of the total market.

(ii) For the purpose of this Subparagraph, a market means direct written insurance premiums in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

(e) An acquisition for which a pre-acquisition notification would be required pursuant to this Section due solely to the resulting effect on the ocean marine insurance line of business.

(f) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition, there is a lack of feasible alternative to improving such condition, the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition, and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

C. Pre-acquisition notification; waiting period. An acquisition covered by Subsection B of this Section may be subject to an order pursuant to Subsection E of this Section unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The commissioner shall give confidential treatment to information submitted under this Subsection in the same manner as provided in R.S. 22:691.10.

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the commissioner relating to those markets, in accordance with Subparagraph (B)(2)(d) of this Section, which cause the acquisition not to be exempted from the provisions of this Section. The commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard set forth in Subsection D of this Section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt of the commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of receipt or termination of the waiting period by the commissioner. Prior to the end of the waiting period the commissioner, on a one-time basis, may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

D. Competitive standard.

(1) The commissioner may enter an order pursuant to Subsection E of this Section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be to substantially lessen competition in any line of insurance in this state or tend to create a monopoly, or if the insurer fails to file adequate information in compliance with the provisions of Subsection C of

this Section.

(2) In determining whether a proposed acquisition would violate the competitive standard set forth in Paragraph (1) of this Subsection, the commissioner shall consider the following:

(a) Any acquisition covered under Subsection B of this Section that involves two or more insurers competing in the same market shall be prima facie evidence of violation of the competitive standards if either of the following circumstances are present:

(i) The market is highly concentrated and the involved insurers possess the following shares of the market:

<COL>Insurer A<COL> <COL>Insurer B<COL>

<COL>4%<COL><COL>4% or more<COL>

<COL>10%<COL><COL>2% or more<COL>

<COL>15%<COL><COL>1% or more.<COL>

(ii) The market is not highly concentrated and the involved insurers possess the following shares of the market:

<COL>Insurer A<COL> <COL>Insurer B<COL>

<COL>5%<COL><COL>5% or more<COL>

<COL>10%<COL><COL>4% or more<COL>

<COL>15%<COL><COL>3% or more<COL>

<COL>19%<COL><COL>1% or more<COL>

(aa) A highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market.

(bb) Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table shall be prima facie evidence of violation of the competitive standard set forth in Paragraph (1) of this Subsection.

(cc) For the purpose of Items (i) and (ii) of this Subparagraph, the insurer with the largest share of the market shall be deemed to be Insurer A.

(b) Whether there is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent or more of the market over a period of time extending from any base year of five to ten years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under Subsection B of this Section involving two or more insurers competing in the same market is prima facie evidence of violation of

the competitive standard set forth in Paragraph (1) of this Subsection if each of the following circumstances exist:

(i) There is a significant trend toward increased concentration in the market.

(ii) One of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share.

(iii) Another involved insurer's market is two percent or more.

(c) For the purposes of this Subsection:

(i) The term "insurer" includes any company or group of companies under common management, ownership, or control.

(ii) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to any applicable definitions or guidelines promulgated by the NAIC and to any relevant information submitted by parties to the acquisition, as well as any other factors the commissioner deems relevant. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being the same one that is used in the annual statement required to be filed by insurers doing business in this state. The relevant geographical market shall be assumed to be this state.

(d) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(e) Even if an acquisition is not a prima facie violation of the competitive standard pursuant to Subparagraphs (a) and (b) of this Paragraph, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even when an acquisition is a prima facie violation of the competitive standard pursuant to Subparagraphs (a) and (b) of this Paragraph, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this Subparagraph include but shall not be limited to market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(3) An order may not be entered pursuant to Subsection E of this Section if either of the following circumstances exists:

(a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition.

(b) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

E. Orders and penalties.

(1)(a) If an acquisition violates the standards of this Section, the commissioner may enter an order which:

(i) Requires an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation.

(ii) Denies the application of an acquired or acquiring insurer for a license to do business in this state.

(b) Such an order shall not be entered unless each of the following requirements have been satisfied:

(i) Interested parties have opportunity for a hearing.

(ii) Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen days prior to the hearing.

(iii) The hearing is concluded and the order is issued no later than sixty days after the date of the filing of the pre-acquisition notification with the commissioner.

(c) Every order shall be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(d) An order issued pursuant to this Paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the commissioner issued in accordance with Paragraph (1) of this Subsection while the order is in effect may be subject to one or more of the following penalties:

(a) A monetary penalty of not more than ten thousand dollars for every day of violation.

(b) Suspension or revocation of the person's license.

(3) Any insurer or other person who fails to make any filing required by this Section, and who fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than fifty thousand dollars.

F. The provisions of R.S. 22:691.12(B) and (C) and 691.14 do not apply to acquisitions covered under Subsection B of this Section.

Added by Acts 2012, No. 294, § 1.

§ 691.6. 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 the provisions of this Section or the provisions of R.S. 22:691. 5(A)(1), (B), and (D), and either the provisions of R.S. 22:691.7(A)(2) or 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 change or addition."

(2) Any insurer which is subject to registration under this Section shall register within fifteen days after it becomes subject to registration, and annually thereafter by the thirtieth of April of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state which is a member of an insurance 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 the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

B. Information and form required. Every insurer subject to registration shall file the registration statement with the commissioner on a form and in a format prescribed by the commissioner, which shall contain a complete and current disclosure of the following 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) A listing of any agreements which are of the type listed below and which have transactions that are outstanding or which have occurred during the last calendar year between the 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.

(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 insurance holding company system.

(5) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the United States Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this Paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC.

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner.

(7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(8) Any other information required by the commissioner by rule or regulation.

(9) Financial statements of the ultimate controlling person in the holding company system as of the end of the person's latest fiscal year.

C. Summary of changes to 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 the 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 an insurer's admitted assets 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 the provisions of R.S. 22:691.7(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 the information is reasonably necessary to enable the insurer to comply with the provisions of this Subpart.

G. Termination of registration. The commissioner shall terminate the registration of any insurer which demonstrates that 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 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 to be filed 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 such insurer, information, or transaction from applicability of the provisions of this Section.

(2) Unless the commissioner determines 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 provisions of Subsection E of this Section and R.S. 22:691.7(A) and 691.8.

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 person filing such a disclaimer shall notify the commissioner of any material change to the affiliations and relationships as reported in the disclaimer within thirty days of the effective date of the change.

L. Enterprise risk filing. The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners. The provisions of this Section shall become effective for the 2014 calendar year report filing cycle.

M. Violations. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this Section within the time specified for filing shall be a violation of this Section.

N. 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.

Added by Acts 2012, No. 294, § 1. Amended by Acts 2014, No. 528, § 1.

§ 691.7. Standards and management of an insurer within an insurance holding company system

A. Transactions within an insurance holding company system.

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable.

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner.

(c) Charges or fees for services performed shall be reasonable.

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(e) The books, accounts, and records of each party to all such transactions shall be 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.

(f) 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 meet its financial needs.

(2) None of the following enumerated transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or

modifications of affiliate agreements previously filed pursuant to this Section, which are subject to any materiality standards contained in Subparagraphs (a) through (g) of this Paragraph, may be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments.

(i) Relevant transactions relative to nonlife insurers shall equal or exceed the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the thirty-first day of December next preceding.

(ii) Relevant transactions relative to life insurers shall equal or exceed three percent of the insurer's admitted assets 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 loans or extensions of credit with the agreement or understanding that the proceeds of the 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 the loans or extensions of credit.

(i) Relevant transactions relative to nonlife insurers shall equal or exceed the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders as of the thirty-first day of December next preceding.

(ii) Relevant transactions relative to life insurers shall equal or exceed three percent of the insurer's admitted assets as of the thirty-first day of December next preceding.

(c) Reinsurance agreements or modifications thereto, including each of the following types of reinsurance agreements:

(i) All reinsurance pooling agreements.

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent of the insurer's surplus 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 non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

(d) All management agreements, service contracts, tax allocation agreements,

guarantees, and all cost-sharing arrangements.

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this Paragraph unless it exceeds the lesser of one-half of one percent of the insurer's admitted assets or ten percent of surplus as regards policyholders as of the thirty-first day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this Paragraph.

(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to R.S. 22:691.3 or authorized under any other Section of this Code, or in non-subsidiary insurance affiliates that are subject to the provisions of this Subpart, are exempt from this requirement.

(g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders. Nothing in this Paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his authority pursuant to R.S. 22:691.13.

(4) The commissioner, in reviewing transactions pursuant to Paragraph (2) of this Subsection, shall consider whether the transactions comply with the standards set forth in Paragraph (1) of this Subsection and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent of the corporation's voting securities.

B. Dividends and other distributions.

(1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

(2) For purposes of this Subsection, an extraordinary dividend or distribution includes 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 the following amounts:

(a) Ten percent of the insurer's surplus as regards policyholders as of the thirty-first day of December next preceding.

(b) The net gain from operations of the insurer if the insurer is a life insurer, or the net income, if the 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. 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. This carryforward 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.

(3) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration shall confer no rights upon shareholders until either the commissioner has approved the payment of the dividend or distribution, or, the commissioner has not disapproved payment within the thirty-day period referred to above.

C. Management of domestic insurers subject to registration.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Subpart.

(2) Nothing in this Section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of Paragraph (A)(1) of this Section.

(3) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person shall be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer, and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of Paragraphs (3) and (4) of this Subsection shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) of this Subsection with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this Subsection, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, is less than three hundred million dollars. An insurer may also make application to the commissioner for a waiver from the requirements of this Subsection based upon unique circumstances. The commissioner may consider various factors, including but not limited to the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. Adequacy of surplus. For purposes of this Subpart, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet 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 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 the judgment of the commissioner the investment so warrants.

Added by Acts 2012, No. 294, § 1.

§ 691.8. 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 have the power to examine any insurer registered under R.S. 22:691.6 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

B. Access to books and records.

(1) The commissioner may order any insurer registered under R.S. 22:691.6 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this Subpart.

(2) To determine compliance with this Subpart, the commissioner may order any insurer registered under R.S. 22:691.6 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. If at the discretion of the commissioner, it appears that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a penalty of one hundred dollars for each day's delay, or may suspend or revoke the insurer's authority.

C. 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.

D. 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 examination in accordance with R.S. 22:1985 through 1988.

E. Compelling production. In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this Section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may issue 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. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. Such persons shall be entitled to the same fees and mileage, if claimed, as a witness in R.S. 13:3661, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

Added by Acts 2012, No. 294, § 1.

§ 691.9. Supervisory colleges

A. Power of commissioner. With respect to any insurer registered under R.S. 22:691.6, and in accordance with Subsection C of this Section, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Subpart. The powers of the commissioner with respect to supervisory colleges include but are not limited to the following:

(1) Initiating the establishment of a supervisory college.

(2) Clarifying the membership and participation of other supervisors in the supervisory college.

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor.

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing.

(5) Establishing a crisis management plan.

B. Expenses. Each registered insurer subject to this Section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with Subsection C of this Section, including reasonable travel expenses. For purposes of this Section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

C. Supervisory college. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with R.S. 691.8, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The commissioner may enter into agreements in accordance with R.S. 22:691.10(C) providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this Section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

Added by Acts 2012, No. 294, § 1.

§ 691.9.1. Group-wide supervision of internationally active insurance groups

A. The commissioner may act as the group-wide supervisor for any internationally active insurance group pursuant to this Section. An insurance holding company system that does not otherwise qualify as an internationally active insurance

group may request that the commissioner make a determination or acknowledgment as to its group-wide supervisor pursuant to this Section. When one of the following applies, the commissioner may acknowledge another regulatory official as the group-wide supervisor when the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States.

(2) Has substantial insurance operations in the United States but not in this state.

(3) Has substantial insurance operations in the United States and this state but the commissioner has determined pursuant to the factors set forth in Subsections B and F of this Section that the other regulatory official is the appropriate group-wide supervisor.

B. In cooperation with other state, federal, and international regulatory agencies, the commissioner shall identify a single group-wide supervisor for an internationally active insurance group. A commissioner identified under this Section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors specified in Paragraphs (1) through (5) of this Subsection and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group. The commissioner shall consider the following factors and the relative scale of each when making a determination or acknowledgment pursuant to this Subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities.

(2) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group.

(3) The location of the executive offices or largest operational offices of the internationally active insurance group.

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be one of the following:

(a) Substantially similar to the system of regulation provided pursuant to the laws of this state.

(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials.

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

C. Notwithstanding any other provision of law, when another regulatory official

is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, the commissioner shall make a determination or acknowledgment pursuant to Subsection B of this Section in the event of material change in the internationally active insurance group that results in one of the following:

(1) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities.

(2) This state being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group.

D. Pursuant to R.S. 22:691.8, the commissioner is authorized to collect from any insurer registered pursuant to R.S. 22:691.6 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to a determination that an internationally active insurance group is subject to group-wide supervision, the commissioner shall notify the insurer registered pursuant to R.S. 22:691.6 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the Louisiana Register and on the internet website of the Department of Insurance the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

E. If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner may engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risk within the internationally active insurance group to ensure that both of the following conditions are met:

(a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management.

(b) Reasonable and effective mitigation measures are in place.

(2) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including but not limited to information about the members of the internationally active insurance group regarding:

(a) Governance, risk assessment, and management.

(b) Capital adequacy.

(c) Material intercompany transactions.

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risk to members of such internationally active insurance groups that are engaged in the business of insurance.

(4) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of R.S. 22:691.10 through supervisory colleges as set forth in R.S. 22:691.9.

(5) Enter into agreements with or obtain documentation from any insurer registered pursuant to R.S. 22:691.6, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state.

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated in this Subsection, as considered necessary by the commissioner.

F. If the commissioner acknowledges that another chief insurance regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner may reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that both of the following conditions are met:

(1) The commissioner's cooperation is in compliance with the laws of this state.

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. When such recognition and cooperation is not reasonably reciprocal, the commissioner may refuse recognition and cooperation.

G. The commissioner may enter into agreements with or obtain documentation from any insurer registered pursuant to R.S. 22:691.6, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group, which provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. The commissioner may promulgate rules and regulations necessary for the administration of this Section.

I. A registered insurer subject to this Section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this Section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.10. Confidential treatment

A. Documents, materials, or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to R.S. 22:691.8 and all information reported or provided to the commissioner pursuant to R.S. 22:691.4(B)(12) and (13), 691.6, 691.7, and 691.9.1 shall be confidential by law and privileged, 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. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

B. Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner or with whom such documents, materials, or other information are shared pursuant to this Subpart 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:

(1) May 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 NAIC and its affiliates and subsidiaries and with state, federal, and international law enforcement authorities, including members of any supervisory college described in R.S. 22:691.9, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, the commissioner may share confidential and privileged documents, material, or information reported pursuant to R.S. 22:691.6(L) only with commissioners of states having statutes or regulations substantially similar to Subsection A of this Section and who have agreed in writing not to disclose such information.

(3) May receive documents, materials, 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.

(4) Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this Subpart consistent with this Subsection that shall:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this Subpart, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators.

(b) Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this Subpart remains with the commissioner and the NAIC's use of the information is subject to the direction of the commissioner.

(c) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this Subpart is subject to a request or subpoena to the NAIC for disclosure or production.

(d) Require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to this Subpart.

D. The sharing of information by the commissioner pursuant to this Subpart shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this Subpart.

E. 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 Subsection C of this Section.

F. Documents, materials, or other information in the possession or control of the NAIC pursuant to this Subpart shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Added by Acts 2012, No. 294, § 1. Amended by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.11. 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 Subpart.

Added by Acts 2012, No. 294, § 1.

§ 691.12. Injunctions; prohibitions against voting securities; sequestration of voting securities

A. Injunctions. If at the discretion of the commissioner, it appears that any insurer or any director, officer, employee, or agent thereof has committed or is about to commit a violation of this Subpart 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 the insurer or director, officer, employee, or agent thereof from violating or continuing to violate this Subpart or any 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. 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 Subpart or of any rule, regulation, or order issued by the commissioner hereunder may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; however, no action taken at any such meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. 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 Subpart 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 R.S. 22:691.4 or any rule, regulation, or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the 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, creditor 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 Subpart 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, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, may order seizure or sequestration of any voting securities of the insurer owned directly or indirectly by the person, and issue such orders as may be appropriate to effectuate the provisions of this Subpart.

D. Site of ownership. Notwithstanding any other provisions of law, for the purposes of this Subpart the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Added by Acts 2012, No. 294, § 1.

§ 691.13. Sanctions

A. Except as provided in R.S. 22:691.5(E)(3), any insurer failing, without just cause, to file any registration statement as required in this Subpart shall be required, after notice and an opportunity to be heard, to pay a penalty of one

hundred dollars for each day's delay, to be recovered by the commissioner of insurance and the penalty so recovered shall be deposited upon receipt in the state treasury. The maximum penalty under this Section is ten thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner 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 shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to or which violate this Subpart shall pay, in their individual capacity, a civil forfeiture of not more than one thousand dollars per violation, after notice and opportunity for a hearing. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the seriousness 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 Subpart or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which is subject to the provisions of R.S. 22:691.7 and which would not have been approved had the approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and opportunity for hearing, the commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors, or the public.

D. Whenever it appears to the commissioner that any insurer or any director, officer, employee, or agent thereof has committed a willful violation of this Subpart, the commissioner may cause criminal proceedings to be instituted by the Nineteenth Judicial District Court in and for the parish of East Baton Rouge, against the insurer or the responsible director, officer, employee, or agent thereof. Any insurer which willfully violates this Subpart may be fined not more than one hundred thousand dollars. Any individual who willfully violates this Subpart may be fined in his individual capacity not more than fifty thousand dollars or be imprisoned with or without hard labor for not more than five years or both.

E. 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 Subpart, 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.

F. If at the discretion of the commissioner, it appears that any person has committed a violation of R.S. 22:691.4 and the violation prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with R.S. 22:731 et seq.

Added by Acts 2012, No. 294, § 1. Amended by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.14. Receivership

If at the discretion of the commissioner, it appears that any person has committed a violation of this Subpart 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 pursuant to the provisions contained in R.S. 22:73, 96, 731 et seq., 2001 et seq., as well as Subpart H of this Part and Chapter 9 of this Code.

Added by Acts 2012, No. 294, § 1.

§ 691.15. 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 either of following:

(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.

(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 Paragraph (1) or (2) of this Subsection 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, 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.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments pursuant to Subsection A of this Section, which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been 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.

D. The maximum amount recoverable under this Section 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, its parent corporation

or holding company, or person who otherwise 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 parent corporation or holding company or person who otherwise controlled it.

Added by Acts 2012, No. 294, § 1.

§ 691.16. Revocation, suspension, or nonrenewal of insurer's authority

If at the discretion of the commissioner, it appears that any person has committed a violation of this Subpart 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, suspend, revoke, or refuse to renew the insurer's license or authority to do business in this state for such period as the commissioner 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.

Added by Acts 2012, No. 294, § 1.

§ 691.17. 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 Subpart may appeal 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 parties so stipulating.

B. The filing of an appeal pursuant to this Section shall stay the application of any rule, regulation, order, or other action of the commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that 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 Subpart may petition the Nineteenth Judicial District Court in and for the parish of East Baton Rouge for a writ of mandamus directing the commissioner to act or make a determination forthwith.

Added by Acts 2012, No. 294, § 1.

§ 691.18. Severability

The provisions of this Subpart are severable. If any provision or item of this Subpart, or application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of this Subpart which are to be given effect without the invalid provision, item, or application of the Subpart.

Added by Acts 2012, No. 294, § 1.

§ 691.19. Substitution of policies; charge by lender prohibited; penalty

A. It shall be unlawful for any person, firm, or corporation engaged in financing the purchase of immovable or movable property, or of lending money on the security of immovable or movable 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.

B. Any violation of any of the provisions of this Section by any person, firm, or corporation shall 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.

Redesignated from R.S. 22:714 by and amended by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1524 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1958, No. 211, §§ 1, 2. Amended by Acts 2009, No. 503, § 1.

§ 691.20. 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 percent 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 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.

Redesignated from R.S. 22:715 by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1525 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966 at 1:50 P.M. Amended by Acts 2009, No. 503, § 1.

§ 691.21. 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.

Redesignated from R.S. 22:716 by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1526 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M.

§ 691.22. 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.

Redesignated from R.S. 22:717 by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1527 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M.

§ 691.23. Sales exempt

The provisions of R.S. 22:691.21 shall not apply to any purchase and sale, or sale and purchase, and the provisions of R.S. 22:691.22 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.

Redesignated from R.S. 22:718 and amended by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1528 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M.

§ 691.24. Arbitrage transactions

The provisions of R.S. 22:691.20 through 691.22 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. 22:49 [1] and 691.20 through 691.27.

Redesignated from R.S. 22:719 and amended by Acts 2012, No. 294, § 1. Renumbered

from R.S. 22:1529 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M.

[1] Repealed by Acts 2009, No. 503.

§ 691.25. "Equity security" defined

The term "equity security" when used in R.S. 22:49,[1] and 691.20 through 691.27, 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.

Redesignated from R.S. 22:720 and amended by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1530 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M.

[1] Repealed by Acts 2009, No. 503.

§ 691.26. Securities exempt

The provisions of R.S. 22:691.20 through 691.22 shall not apply to such equity securities of a domestic stock insurance company if either of the following apply:

(1) 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.

(2) 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. 22:691.20 through 691.22 except for the provisions of this Paragraph.

Redesignated from R.S. 22:722 and amended by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1532 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M. Amended by Acts 2009, No. 503, § 1.

§ 691.27. 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. 22:49,[1] and 691.20 through 691.27 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: 691.20 through 691.22 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.

Redesignated from R.S. 22:723 and amended by Acts 2012, No. 294, § 1. Renumbered from R.S. 22:1533 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 8, § 1, eff. June 9, 1966, at 1:50 P.M. Amended by Acts 2009, No. 503, § 1.

[1] Repealed by Acts 2009, No. 503.

SUBPART G-2. RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT

Redesignation of Part

Another Subpart G-2, "Corporate Governance Annual Disclosure Act", enacted by Acts 2015, No. 304, § 1, was redesignated Subpart G-3, in 2015, pursuant to the statutory revision authority of the Louisiana State Law Institute.

§ 691.31. Purpose and scope

A. The purpose of this Subpart is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment (ORSA) and the guidance and instructions for filing an ORSA summary report with the commissioner.

B. The requirements of this Subpart shall apply to all domestic insurers unless exempt pursuant to R.S. 22:691.36.

C. The legislature finds and declares that the ORSA summary report will contain confidential and sensitive information related to the identification of risk material and relevant to the insurer or insurance group filing the report. Public disclosure of the information in the ORSA summary report will cause harm to and competitive disadvantage for the insurer or insurance group. The legislature intends that the ORSA summary report be filed with the commissioner as a confidential document, shared only as stated in this Subpart to assist in the performance of the commissioner's duties, and exempted from public disclosure.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.32. Definitions

For purposes of this Subpart:

(1) "Insurance group" means, for the purpose of conducting an ORSA, those insurers and affiliates included within an insurance holding company system as defined in R.S. 22:691.2(5).

(2) "Insurer" means an insurer as defined in R.S. 22:46 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.

(3) "NAIC" means the National Association of Insurance Commissioners.

(4) "Own risk and solvency assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer's or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

(5) "ORSA Guidance Manual" means the current version of the "Own Risk and Solvency Assessment Guidance Manual" developed and adopted by the NAIC and as amended from time to time. A change in the ORSA Guidance Manual shall become effective on January first following the calendar year in which the changes are adopted by the NAIC.

(6) "ORSA summary report" means a confidential high-level summary of an insurer's or insurance group's ORSA.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.33. Risk management framework

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which it is a member maintains a risk management framework applicable to the operations of the insurer.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.34. ORSA requirement

Subject to R.S. 22:691.36, an insurer, or the insurance group of which it is a member, shall regularly conduct an ORSA consistent with the ORSA Guidance Manual. An insurer, or the insurance group of which it is a member, shall conduct the ORSA no less than annually and any time there are significant changes to the risk profile of the insurer or the insurance group of which it is a member.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.35. ORSA summary report

A. Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA summary report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer, the insurance group of which it is a member, or both. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report required by this Subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

B. The report shall include a signature and an attestation based on the knowledge, information, and belief of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the

report has been provided to the insurer's board of directors or the appropriate committee of such board.

C. An insurer may comply with Subsection A of this Section by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which it is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.36. Exemption

A. An insurer shall be exempt from the requirements of this Subpart, if both of the following apply:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than five hundred million dollars.

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, less than one billion dollars.

B. If an insurer qualifies for exemption pursuant to Paragraph (1) of Subsection A of this Section, but the insurance group of which it is a member does not qualify for exemption pursuant to Paragraph (2) of Subsection A of this Section, the ORSA summary report that may be required pursuant to R.S. 22:691.35 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

C. If an insurer does not qualify for exemption pursuant to Paragraph (1) of Subsection A of this Section, but the insurance group of which it is a member qualifies for exemption pursuant to Paragraph (2) of Subsection A of this Section, then the only ORSA summary report that may be required pursuant to R.S. 22:691.35 shall be the report applicable to that insurer.

D. An insurer that does not qualify for exemption pursuant to Subsection A of this Section may apply to the commissioner for a waiver from the requirements of this Subpart based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership, and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which it is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

E. Notwithstanding the exemptions stated in this Section:

(1) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report based on unique circumstances, including but not limited to the type and volume of business written, ownership, and organizational structure, federal agency requests, and international supervisor requests.

(2) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report if the insurer has a risk-based capital company-action level event as set forth in R.S. 22:611 et seq. or 631 et seq., meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in regulations promulgated by the commissioner, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

F. If an insurer ceases to qualify for an exemption pursuant to Subsection A of this Section due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which it is a member, the insurer shall have one year following the year the premium threshold is exceeded to comply with the requirements of this Subpart.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.37. Contents of ORSA summary report

A. The ORSA summary report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of Subsection B of this Section. Documentation and supporting information shall be maintained and made available upon examination by or request of the commissioner.

B. The review of the ORSA summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.38. Confidentiality

A. Documents, materials, or other information, including the ORSA summary report, in the possession or control of the commissioner that are obtained by, created by, or disclosed to the commissioner or any other person pursuant to this Subpart are proprietary and contain trade secrets. All such documents, materials, or other information shall be confidential and privileged, shall not be subject to disclosure under the Public Records Law, 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 may 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. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

B. Neither the commissioner nor any person who receives documents, materials, or

other ORSA-related information, through examination or otherwise, while acting pursuant to the authority of the commissioner or with whom such documents, materials, or other information are shared pursuant to this Subpart 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 regulatory duties, the commissioner:

(1) May, upon request, share documents, materials, or other ORSA-related information, including the confidential and privileged documents, materials, or information subject to Subsection A of this Section, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in R.S. 22:691.9, with the NAIC, and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(2) May receive documents, materials, or other ORSA-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in R.S. 22:691.9, and from the NAIC, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged pursuant to the laws of the jurisdiction that is the source of the document, material, or information.

(3) Shall enter into a written agreement with the NAIC or a third-party consultant governing the sharing and use of information provided pursuant to this Subpart, consistent with this Subsection that shall include all of the following:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this Subpart, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(b) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this Subpart remains with the commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the commissioner.

(c) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this Subpart in a permanent database after the underlying analysis is complete.

(d) Require prompt notice be given to an insurer whose confidential information

in the possession of the NAIC or a third-party consultant pursuant to this Subpart is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production.

(e) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this Subpart.

(f) Provide for the insurer's written consent in the case of an agreement involving a third-party consultant.

D. The sharing of information and documents by the commissioner pursuant to this Subpart shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this Subpart.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner pursuant to this Section or as a result of sharing as authorized in this Subpart.

F. Documents, materials, or other information in the possession or control of the NAIC or third-party consultants pursuant to this Subpart shall be confidential and privileged, shall not be subject to disclosure pursuant to the Public Records Law, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

§ 691.39. Sanctions

Any insurer failing, without just cause, to timely file the ORSA summary report as required by this Subpart shall be required, after notice and an opportunity to be heard, 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 deposited upon receipt in the state treasury. The maximum penalty under this Section shall be ten thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Added by Acts 2015, No. 196, § 1, eff. Jan. 1, 2016.

SUBPART G-3. CORPORATE GOVERNANCE ANNUAL DISCLOSURE ACT

Redesignation of Part

This Subpart, originally enacted by Acts 2015, No. 304, § 1, as Subpart G-2, comprised of R.S. 22:691.31 to 22:691.38, was redesignated as Subpart. G-3, comprised of R.S. 22:691.51 to 22:691.58, in 2015, pursuant to the statutory revision authority of the Louisiana State Law Institute.

§ 691.51. Purpose and scope

A. The purpose of this Subpart is to:

(1) Provide the commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

(2) Outline the requirements for completing a corporate governance annual disclosure with the commissioner.

(3) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

B. Nothing in this Subpart shall be construed to prescribe or impose corporate governance standards and internal procedures beyond those required pursuant to this Title or other laws of this state. Notwithstanding any other provision of this Subpart to the contrary, nothing in this Subpart shall be construed to limit the commissioner's authority or the rights or obligations of third parties pursuant to this Title.

C. The requirements of this Subpart shall apply to all insurers domiciled in this state.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.52. Definitions

For purposes of this Subpart:

(1) "Corporate governance annual disclosure" or "CGAD" means a confidential report filed by the insurer or insurance group compiled in accordance with the requirements of this Subpart.

(2) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in the Insurance Holding Company System Regulatory Law, R.S. 22:691.1 et seq.

(3) "Insurer" means an insurer as defined in R.S. 22:46, 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.

(4) "NAIC" means the National Association of Insurance Commissioners.

(5) "ORSA summary report" means a confidential high-level summary of an insurer's or insurance group's own risk and solvency assessment.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.53. Disclosure requirement

A. An insurer, or the insurance group of which the insurer is a member, shall, no later than June first of each calendar year, submit to the commissioner a corporate governance annual disclosure (CGAD) that contains the information specified in R.S. 22:691.55. Notwithstanding any request from the commissioner made pursuant to Subsection C of this Section, if the insurer is a member of an insurance group, the insurer shall submit the report required by this Section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

B. The CGAD shall include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or its appropriate committee.

C. An insurer not required to submit a CGAD under this Section shall do so upon the commissioner's request.

D. For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group shall be encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or

the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

E. The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures outlined in the most recent Financial Analysis Handbook specified in Subsection A of this Section.

F. Insurers providing information substantially similar to the information required by this Subpart in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements or other state or federal filings provided to the commissioner, shall not be required to duplicate that information in the CGAD but shall be required only to make reference to the document in which such information is included.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.54. Rules and regulations

Pursuant to the Administrative Procedure Act and this Title, the commissioner may promulgate rules, regulations, and orders necessary to carry out the provisions of this Subpart.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.55. Contents of corporate governance annual disclosure

A. The insurer or insurance group shall have discretion over the responses to

the CGAD inquiries; however, the CGAD shall contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices. The commissioner may request additional information deemed material and necessary to provide a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies.

B. Notwithstanding Subsection A of this Section, the CGAD shall be prepared consistently with rules, regulations, and orders promulgated pursuant to R.S. 22:691.54. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.56. Confidentiality

A. Documents, materials, or other information, including the CGAD, in the possession of or control of the commissioner that are obtained by, created by, or disclosed to the commissioner or any other person pursuant to this Subpart are recognized by this state as being proprietary and containing trade secrets. All such documents, materials, or other information shall be confidential and privileged, shall not be subject to the Public Records Law, 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. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this Section shall be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other governance-related information pursuant to Subsection C of this Section to assist in the performance of the commissioner's regular duties.

B. Neither the commissioner nor any person who received documents, materials, or other governance-related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom such documents, materials, or other information are shared pursuant to this Subpart 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 regulatory duties,

the commissioner may do either or both of the following:

(1) Upon request, share documents, materials, or other governance-related information, including the confidential and privileged documents, materials, or information subject to Subsection A of this Section, including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in R.S. 22:691.9, with the NAIC, and with third-party consultants pursuant to R.S. 22:691.57; however, the recipient shall agree in writing to maintain the confidentiality and privileged status of the governance-related documents, materials, or other information and shall verify in writing its legal authority to maintain such confidentiality.

(2) Receive documents, materials, or other governance-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in R.S. 22:691.9, and from the NAIC and shall maintain as confidential or privileged any documents, materials, 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, materials, or information.

D. The sharing of information and documents by the commissioner pursuant to this Subpart shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner shall be solely responsible for the administration, execution, and enforcement of the provisions of this Subpart.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other governance-related information shall occur as a result of disclosure of such governance-related information or documents to the commissioner under this Section or as a result of sharing as authorized in this Subpart.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.57. NAIC and third-party consultants

A. The commissioner may retain, at the insurer's expense, third-party consultants, including 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 CGAD and related information or the

insurer's compliance with this Subpart.

B. Any person retained pursuant to Subsection A of this Section shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

C. The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the commissioner.

D. As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this Subpart.

E. A written agreement with either the NAIC, a third-party consultant, or both governing sharing and use of information provided pursuant to this Subpart shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided pursuant to this Subpart:

(1) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this Subpart.

(2) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(3) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the commissioner and the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner.

(4) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this Subpart in a permanent database after the underlying analysis is complete.

(5) A provision requiring the NAIC or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information.

(6) A requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this Subpart.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§ 691.58. Sanctions

Any insurer failing, without just cause, to timely file the CGAD as required by this Subpart shall be required, after notice and an opportunity to be heard, 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 deposited upon receipt in the state treasury. The maximum penalty under this Section shall be ten thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Added by Acts 2015, No. 304, § 1, eff. Jan. 1, 2016.

Severability—Acts 2015, No. 302

Section 3 of Acts 2015, No. 304, as modified pursuant to the statutory revision authority of the Louisiana State Law Institute, provides:

"Notwithstanding the provisions of R.S. 24:175, the provisions of this Act are nonseverable. It is intended that if any provision of R.S. 22:691.56, as enacted by Section 1 of this Act, or the application thereof to any person or circumstances is held invalid under the Constitution of Louisiana or of the United States by a final and nonappealable judgment, then such provision's ineffectiveness or invalidity will invalidate this Act."

§§ 692 to 694. Repealed by Acts 2012, No. 294, § 2

§§ 695 to 702. Redesignated as 22:232.1 to 22:232.8 by Acts 2012, No. 294, § 3

§§ 703 to 713. Repealed by Acts 2012, No. 294, § 2

§§ 714 to 720. Redesignated as 22:691.19 to 22:691.25 by Acts 2012, No. 294, § 1

§ 721. Repealed by Acts 2012, No. 294, § 2

§§ 722, 723. Redesignated as 22:691.26, 22:691.27 by Acts 2012, No. 294, § 1

§ 724. Repealed by Acts 2009, No. 503, § 2

SUBPART H. ADMINISTRATIVE SUPERVISION

§ 731. 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 this 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. 22:731 through 736. This determination by the commissioner shall be subject to review in accordance with the Administrative Procedure Act.[1]

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. 22:731 through 736.

D. If the commissioner determines after due notice 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.

F. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:768 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 997, § 1. Amended by Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1.

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

§ 732. 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 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.

Renumbered from R.S. 22:769 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 997, § 1. Amended by Acts 2009, No. 317, § 1.

§ 733. 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.

Renumbered from R.S. 22:770 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 997, § 1.

§ 734. 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.

Renumbered from R.S. 22:771 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 997, § 1.

§ 735. Administrative election of proceedings

Nothing contained in this Subpart 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 Subpart against the insurer.

Renumbered from R.S. 22:772 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 997, § 1.

§ 736. Administrative rules

The commissioner may adopt reasonable rules, including fines and penalties for violations of R.S. 22:733, necessary for the implementation of the provisions herein, pursuant to the Administrative Procedure Act.[1]

Renumbered from R.S. 22:773 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 997, § 1.

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

§ 737. 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 Subpart pursuant to the Administrative Procedure Act.[1]

Renumbered from R.S. 22:774 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 437, § 1. Amended by Acts 1999, No. 1304, § 1, eff. July 12, 1999.

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

PART IV. RESERVES

SUBPART A. LIFE INSURANCE RESERVES

§ 751. 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. On or 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 Subpart.

(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 Subpart.

(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 Subpart. However, certain policies described in R.S. 22:142 and 143 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) Repealed by Acts 2009, No. 503, § 2.

(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 this Title 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. 22:936 shall not apply to policies and contracts approved for issuance only to residents of foreign countries.

Renumbered from R.S. 22:162 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1.

§ 752. Actuarial opinion reserves

A. Prior to the operative date of the valuation manual, 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) 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 required by Subsections A and B of this Section 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 as of the end of that year.

(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 Subpart, "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.

E. On and after the operative date of the valuation manual, every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the commissioner shall annually:

(1) Submit an opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with the laws of this state.

(2) Include in the opinion required by Paragraph (1) of this Subsection, unless exempted in the valuation manual, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company in support of the reserves and related actuarial items, including but not limited to the investment earnings from the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

F. Each opinion required by Subsection E of this Section shall be governed by the following:

(1) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual 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 prepare the supporting memorandum required by the commissioner.

(2) The opinion and memorandum shall be in accordance with the form and substance prescribed in the valuation manual and acceptable to the commissioner.

(3) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(4) The opinion shall apply to all policies and contracts subject to Paragraph (E)(2) of this Section, plus other actuarial liabilities as may be specified in the valuation manual.

(5) The opinion shall be based on standards adopted by the Actuarial Standards Board, or its successor, and on additional standards that may be prescribed in the valuation manual.

(6) 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.

(7) Except in cases of fraud or willful misconduct, the appointed 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 appointed actuary's opinion.

(8) Disciplinary action by the commissioner against the company or the appointed actuary shall be in accordance with this Title and rules or regulations promulgated by the commissioner.

Renumbered from R.S. 22:162.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 704, § 1. Amended by Acts 2009, No. 503, § 1; Acts 2013, No. 349, § 1, eff. Jan. 1, 2014.

§ 753. Policies under standard valuation law

A. (1) The mortality, interest, and other standards specified in R.S. 22:751 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. 22:936. 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. 22:751.

B. For policies and contracts issued prior to the operative date of the valuation manual:

(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 September 7, 1979, the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after September 7, 1979, and prior to January 1, 1989; 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 January 1, 1989, 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 September 7, 1979, 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 on or after January 1, 1981, 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 Subpart 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 on or after January 1, 1981, 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 Subpart 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) of this Subsection 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 on or after January 1, 1981, 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 on or after January 1, 1981, 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 on or after January 1, 1981, 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 Items (i), (ii), (iii), and (iv) of this Subparagraph 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 Paragraph (1) or (2) of this Subsection.

(i) All life insurance policies issued in a particular calendar year, on or after January 1, 1989.

(ii) All individual annuity and pure endowment contracts issued on or after January 1, 1983.

(iii) All group annuities and pure endowments on or after January 1, 1983.

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

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

<COL>(aa) For life insurance: $I = .03 + W (R_1 - .03) +$<COL>$W$<COL>$(R_2 - .09)$.

<COL><COL>2<COL>

(bb) 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 Subparagraph (d) of this Paragraph; and W is the weighting factor defined in Subparagraph (c) of this Paragraph.

(cc) 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 Subitem (bb) of this Item, the formula for life insurance stated in Subitem (aa) of this Item 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 Subitem (bb) of this Item shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less.

(dd) 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 Subitem (bb) of this Item shall apply.

(ee) 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 Subitem (bb) of this Item 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 this 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.

(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 in Subparagraph (b) of this Paragraph shall be as provided in the following tables:

(i) Weighting factors for life insurance:

<COL>Guarantee Duration in years<COL>Weighting

<COL><COL>Factors

<COL>10 years or less<COL>.50

<COL>More than 10, but not more than 20 years<COL>.45

<COL>More than 20 years<COL>.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 Item (ii) of this Subparagraph, shall be as specified in Subitems (aa), (bb), and (cc) of this Item according to the provisions in Subitems (dd), (ee), and (ff) of this Item:

(aa) For annuities and guaranteed interest contracts valued on an issue year basis:

<COL> <COL>Weighting Factor

<COL>Guarantee<COL>for Plan Type

<COL>Duration in Years<COL>A<COL>B<COL>C

<COL>5 years or less:<COL>.80<COL>.60<COL>.50

<COL>More than 5 years, but not more than 10 years:<COL>.75<COL>.60<COL>.50

<COL>More than 10 years, but not more than 20 years:<COL>.65<COL>.50<COL>.45

<COL>More than 20 years:<COL>.45<COL>.35<COL>.35

<COL>(bb)<COL>Plan Type

<COL> <COL>A<COL>B<COL>C

For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Subparagraph (a) of this Paragraph increased by:<COL>.15<COL>.25<COL>.05

<COL>(cc)<COL>Plan Type

<COL> <COL>A<COL>B<COL>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 Subitem (aa) or derived in Subitem (bb) increased by:<COL>.05.<COL>05<COL>.05

(dd) 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.

(ee) The plan type as used in the above tables is defined as follows:

<COL>Plan Type A:<COL>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.

<COL>Plan Type B:<COL>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.

<COL>Plan Type C:<COL>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.

(ff) 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 Corporate 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 Corporate 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 Subitem (c)(iii)(bb) of this Paragraph 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 Corporate 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 Item (ii) of this Subparagraph, 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 Corporate 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 Corporate 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 Corporate Bonds as published by Moody's Investors Service, Inc.

(e) In the event that the Monthly Average of the Composite Yield on Seasoned Corporate 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 Corporate 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 Item (i) of this Subparagraph over Item (ii) of this Subparagraph 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) of this Subsection be the greater of the reserve as of such policy anniversary calculated as described in Subparagraph (a) of this Paragraph and the reserve as of such policy anniversary calculated as described in that Subparagraph, but with the value defined in that Subparagraph 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) of this Subsection 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. 22:752.

(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 shall be applied as if the method actually used in calculating the reserve for such policy were the method described in Paragraph (4) of this Subsection, ignoring Subparagraph (b) of that Paragraph. 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) of this Subsection, including Subparagraph (b) of that Paragraph, and the minimum reserve calculated in accordance with this Paragraph.

(9) Nothing in this Subsection shall apply to any policy issued by any insurer subject to the provisions of Subparts D and E of Part I of this Chapter, R.S. 22:131 et seq. and R.S. 22:141 et seq., 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) of this Subsection, 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. For policies issued on or after the operative date of the valuation manual:

(1) The standard prescribed in the valuation manual is the minimum standard of valuation required under R.S. 22:751(A), except as provided under Paragraph (5) or (7) of this Subsection.

(2) The operative date of the valuation manual is January first of the first calendar year following the first July first as of which all of the following have occurred:

(a) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two members, or three-fourths of the members voting, whichever is greater.

(b) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(c) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the fifty-five NAIC member jurisdictions.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January first following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(a) At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership.

(b) Members of the NAIC representing jurisdictions totaling greater than seventy-five percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in Subparagraph(a) of this Paragraph: life, accident and health annual statements, health annual statements, or fraternal annual statements.

(4) For policies not subject to a principle-based valuation under Subsection D of this Section, the minimum valuation standard shall use one of the following:

(a) The minimum valuation standard that was in effect prior to the operative date of the valuation manual.

(b) A reserve standard that quantifies the benefits, guarantees, and funding associated with the contract risk and a level of conservatism that reflects all unfavorable events that have a reasonable probability of occurring.

(5) In the absence of a specific valuation requirement, the company shall comply with minimum valuation standards prescribed by the commissioner by rule or regulation.

(6) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any valuation requirement. The commissioner may rely upon the opinion of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States.

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary to comply with the requirements of the valuation manual, and the company shall adjust the reserves as required by the commissioner.

(8) Upon written application of a domestic insurer, the commissioner may exempt the insurer or specific product forms or lines from the requirements of this Subsection.

D. (1) For policies or contracts specified in the valuation manual as being subject to principle-based valuation, a company shall establish reserves that:

(a) Quantify the benefits, guarantees, and funding associated with the contracts and their risk at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts, including conditions appropriately adverse to quantify any significant tail risk.

(b) Incorporate assumptions, risk analysis methods, financial models, and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(c) Incorporate assumptions that are derived from one of the following:

(i) The valuation manual.

(ii) When not prescribed in the valuation manual, one of the following:

(aa) The company's available, relevant, and statistically credible experience.

(bb) To the extent that company data are not available, relevant, or statistically credible, other available, relevant, and statistically credible experience.

(d) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) As specified in the valuation manual, a company using a principle-based valuation for one or more policies or contracts shall:

(a) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(b) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the principle-based valuation internal controls. The controls shall be designed to assure that all material risks are included in the valuation in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(c) Develop a principle-based valuation report that complies with standards prescribed in the valuation manual and file it with the commissioner when requested.

(3) A principle-based valuation may include a prescribed formulaic reserve component.

E. For policies in force on or after the operative date of the valuation manual, a company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

F. 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 provided in this Section may, with the approval of the commissioner of insurance, adopt any lower standard of valuation, but not lower than the minimum provided in this Section. However, for purposes of this Section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by this Subpart shall not be deemed to be the adoption of a higher standard of valuation.

G. For purposes of this Subpart, "confidential information" shall mean:

(1) A memorandum in support of an opinion submitted under this Section and any other documents, materials and other information, including but not limited to all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such

memorandum.

(2) All documents, materials and other information, including but not limited to all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under this Section provided, however, that if an examination report or other material prepared in connection with an examination made under Chapter 8 of this Title is not held as private and confidential information under Chapter 8 of this Title, an examination report or other material prepared in connection with an examination made under this Section shall not be confidential information to the same extent as if such examination report or other material had been prepared under Chapter 8 of this Title.

(3) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under this Section evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including but not limited to all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials, and other information.

(4) Any principle-based valuation report developed under this Section and any other documents, materials and other information, including but not limited to all working papers, and copies thereof, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with such report.

(5) Any documents, materials, data and other information submitted by a company under this Section, to be known collectively as "experience data" and any other documents, materials, data and other information, including but not limited to all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner together with any experience data, the experience materials, and any other documents, materials, data and other information, including but not limited to all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

H. Privilege for, and confidentiality of, confidential information.

(1) Except as provided in this Section, a company's confidential information is confidential by law and privileged, and shall not be subject to the Public Records Law, R.S. 44:1.1 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 confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(2) Neither the commissioner nor any person who received confidential information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(3) In order to assist in the performance of the commissioner's duties, the commissioner may share confidential information (a) with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries and (b) in the case of confidential information specified in Paragraphs (G)(1) and (4) of this Section only, with the Actuarial Board for Counseling and Discipline, or its successor, upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials; in the case of Subparagraphs (a) and (b) of this Paragraph, provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner.

(4)(a) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline, or its successor, and shall maintain as confidential or privileged any document, material, data or other 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 other information.

(b) The commissioner may enter into agreements governing sharing and use of information consistent with this Subsection.

(5) Repealed by Acts 2014, No. 635, § 3, eff. June 12, 2014.

(6) No waiver of any applicable privilege or claim of confidentiality in the confidential 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.

(7) 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.

(8) In this Section "regulatory agency", "law enforcement agency", and the "NAIC" include but are not limited to their employees, agents, consultants, and contractors.

I. Notwithstanding Subsection H of this Section, any confidential information specified in Paragraphs (G)(1) and (4) of this Section:

(1) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under R.S. 22:752 or principle-based valuation report developed under this Section by reason of an action required by this Subpart or by regulations promulgated hereunder.

(2) May otherwise be released by the commissioner with the written consent of the company.

(3) Once any portion of a memorandum in support of an opinion submitted under R.S. 22:752 or a principle-based valuation report developed under this Section is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

J. For the purposes of this Subpart, the following definitions shall apply on and after the operative date of the valuation manual:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required by R.S. 22:752.

(3) "Company" means an entity that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts and one of the following:

(a) Has at least one such policy or contract in force or on claim in this state.

(b) Meets the requirement to hold a certificate of authority to write such policies or contracts in this state and has written, issued, or reinsured such policies or contracts in any state.

(4) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks, and as may be specified in the valuation manual.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this Subpart including but not limited to lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(7) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with Subsection D of this Section as specified in the valuation manual.

(8) "Qualified actuary" means an individual qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and meets the requirements specified in the valuation manual.

(9) "Tail risk" means risk that occurs either when the frequency of low probability events is higher than expected under a normal probability

distribution or when there are observed events of very significant size or magnitude.

(10) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this Subpart including any subsequent amendments.

Renumbered from R.S. 22:163 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1; Acts 2013, No. 349, § 1, eff. Jan. 1, 2014.

Severability—Acts 2014, No. 635

Section 4 of Acts 2014, No. 635 provides:

"Section 4. If any provision or provisions of this Act or its application to a particular circumstance is held to be invalid by a court of competent jurisdiction, the invalidity does not affect the other provisions or applications of this Act. A court of competent jurisdiction shall properly sever provisions that are held to be invalid, and the valid portions, provisions, or applications shall retain full force and effect."

§ 754. Dividends; payments limited when reserve deficient

A. 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 provided in R.S. 22:753, 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.

B. However, in the case of any insurer availing itself of the reduction in the reserves allowed in R.S. 22:751 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 Subsections A, B, C, and D of R.S. 22:751.

Renumbered from R.S. 22:164 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 755. 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. 22:754 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.

Renumbered from R.S. 22:165 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

SUBPART B. RESERVES FOR INSURANCE OTHER THAN LIFE

§ 761. Unearned premium reserve

A. With reference to insurance against loss or damage to property, except as provided in R.S. 22:763, and with reference to all general casualty insurance, health and accident insurance except as provided in R.S. 22:764, 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<COL><COL>Reserve for Unearned Premium

One year, or less<COL><COL>1/2<COL>

Two years:<COL><COL><COL>

<COL>First year<COL><COL>3/4<COL>

<COL>Second year<COL><COL>1/4<COL>

Three years:<COL><COL><COL>

<COL>First year<COL><COL>5/6<COL>

<COL>Second year<COL><COL>1/2<COL>

<COL>Third year<COL><COL>1/6<COL>

Four years:<COL><COL>

<COL>First year<COL><COL>7/8<COL>

<COL>Second year<COL><COL>5/8<COL>

<COL>Third year<COL><COL>3/8<COL>

<COL>Fourth year<COL><COL>1/8<COL>

Five years:<COL><COL><COL>

<COL>First year<COL><COL>9/10<COL>

<COL>Second year<COL><COL>7/10<COL>

<COL>Third year<COL><COL>1/2<COL>

<COL>Fourth year<COL><COL>3/10<COL>

<COL>Fifth year<COL><COL>1/10<COL>

Over five years<COL><COL>Pro rata<COL>

(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.

Renumbered from R.S. 22:891 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996.

§ 762. 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 of this Section, policy fees shall not be included in the compilation of actual or projected annual net premiums.

Renumbered from R.S. 22:891.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 881, § 1, eff. Jan. 1, 1991. Amended by Acts 1991, No. 207, § 1, eff. July 2, 1991.

§ 763. 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 percent 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.

Renumbered from R.S. 22:892 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 764. 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.

Renumbered from R.S. 22:893 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1999, No. 878, § 1, eff. July 2, 1999.

§ 765. 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.

Renumbered from R.S. 22:894 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 766. 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.

Renumbered from R.S. 22:895 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1997, No. 549, § 1.

§ 767. Schedule of experience

Any insurer transacting any liability or workers' 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.

Renumbered from R.S. 22:900 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 768. Special reserve fund; title insurance

A. 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 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.

B. 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.

C. For the purposes of computing the special reserve fund as provided in 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.

Renumbered from R.S. 22:901 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 769. Increased reserves

A. 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 Subpart.

B. 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.

Renumbered from R.S. 22:902 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 770. "Loss payments" and "loss expense payments" defined

"Loss payments" and "loss expense payments" as used with reference to liability and workers' 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.

Renumbered from R.S. 22:903 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 771. Statement of actuarial opinion

A. Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of a qualified actuary appointed by the company entitled "statement of actuarial opinion". This opinion shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions.

B. (1) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the actuarial opinion required in Subsection A of this Section.

(2) A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

C. (1) An actuarial report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting actuarial report or workpapers at the request of the commissioner or if the commissioner determines that the supporting actuarial report or workpapers provided by the insurance company 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 prepare the supporting actuarial report or workpapers.

D. Except in cases of fraud or willful misconduct, the appointed 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.

E. The statement of actuarial opinion shall be provided with the annual statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be treated as a public document.

F. All documents, materials or other information in the possession or control of the commissioner that are considered an actuarial report, workpapers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the commissioner in connection with the actuarial report, workpapers or actuarial opinion summary, 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 that any access may be granted to the National Association of Insurance Commissioners, insurance departments of other states, international, federal or state law enforcement agencies or international, federal or state regulatory agencies with statutory oversight over the financial services industry, if the recipient agrees to maintain the

confidentiality of those documents which are confidential under the laws of this state. Nothing contained in this Subsection shall be construed to limit the commissioner's authority to use any document, material or other information in the furtherance of any legal or regulatory action which the commissioner may, in his sole discretion, deem appropriate.

Renumbered from R.S. 22:904 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996. Amended by Acts 1997, No. 549, § 1; Acts 2009, No. 503, 1; Acts 2010, No. 211, § 1.

SUBPART C. SEPARATE ACCOUNTS

§ 781. 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. 22:584, except that the quantitative limitations contained in such Subsections A through G of R.S. 22:584 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. 22:584 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 Subpart B of Part III of this Chapter, R.S. 22:581 et seq., 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. 22:2042(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 of this Section, 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)(a) 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.

(b) 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 R.S. 22:781 and 914; 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 commissioner of financial institutions.

Renumbered from R.S. 22:1500(A) to (J) by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1.

CHAPTER 3. DEPOSITS, ASSESSMENTS, FEES AND TAXES

PART I. GENERAL PROVISIONS

§ 791. Exemption from franchise or capital stock tax

No insurer paying the taxes levied under this Part shall be liable for any franchise or capital stock tax.

Renumbered from R.S. 22:1069 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 792. 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 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.

Renumbered from R.S. 22:1070 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2001, No. 183, § 1, eff. Jan. 1, 2002; Acts 2009, No. 503, § 1.

§ 793. 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 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 tax may be due as may be necessary to enforce a full and fair compliance with the provisions of this Part.

Renumbered from R.S. 22:1073 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 794. Cost of collection and supervision

The commissioner of insurance is authorized to withhold from the funds collected under this Part, a sum 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.

Renumbered from R.S. 22:1074 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 795. Disposition of collections

A. Except as provided in R.S. 22:794 and R.S. 22:821, the commissioner of insurance shall keep complete books and records to show the amount of taxes collected by him, and shall deposit all collections made by him under this Part into the state treasury.

B. Except as provided in R.S. 22:794 and R.S. 22:821, all 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.

Renumbered from R.S. 22:1075 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 796. Collection of delinquent taxes and fees; additional amounts to be collected

The commissioner is authorized to collect any delinquent taxes and fees under this Chapter, or to represent the department in any proceeding under this Chapter. If any delinquent taxes or fees due under this Chapter 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.

Renumbered from R.S. 22:1081 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 703, § 1. Amended by Acts 2009, No. 503, § 1.

PART II. DEPOSITS

§ 801. 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. 22:804, 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 one hundred 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 one hundred thousand dollars has been made. Such approval shall be made by the commissioner of insurance.

Renumbered from R.S. 22:1021 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2008, No. 504, § 1, eff. Jan. 1, 2009.

§ 802. Condition of deposit

The deposit required by R.S. 22:801 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.

Renumbered from R.S. 22:1022 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 81, § 1, eff. June 29, 1979; Acts 2009, No. 503, § 1.

§ 803. Repealed by Acts 2008, No. 504, § 2, eff. Jan. 1, 2009

§ 804. Exception

A. Any 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 five 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. 22:801.

B. Proof in the form of original home state certifications shall be delivered to the commissioner of insurance no later than the first of March each year and dated no earlier than the last day of December of the prior year.

Renumbered from R.S. 22:1024 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2008, No. 504, § 1, eff. Jan. 1, 2009.

§§ 805, 806. Repealed by Acts 2008, No. 504, § 2, eff. Jan. 1, 2009

§ 807. Withdrawals

Withdrawal of any bond or deposit required by R.S. 22:801 through 808 may be made only upon approval by the commissioner. A withdrawal of a bond or deposit required by R.S. 22:801 or this Section shall be in accordance with the provisions of R.S. 22:341. In the case of a domestic insurer placed in rehabilitation or liquidation by the commissioner, the deposit required by R.S. 22:808 shall be surrendered to the receiver pursuant to an order of the receivership court. Upon release from rehabilitation or liquidation, the insurer shall comply with all applicable provisions of this Part.

Renumbered from R.S. 22:1027 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2008, No. 504, § 1, eff. Jan. 1, 2009; Acts 2015, No. 35, § 1, eff. June 5, 2015.

§ 808. 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.

Renumbered from R.S. 22:1028 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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.

§ 809. Registered policies; deposit

A. Any 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 purposes of this Section, the securities referred to in this Subsection 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. 22:581 through R.S. 22:596. 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.

Renumbered from R.S. 22:1029 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 235, § 1; Acts 1981, No. 672, § 1; Acts 1982, No. 748, § 1; Acts 2009, No. 503, § 1.

PART III. FEES

§ 821. Fees

A. The fee for filing the power of attorney shall be collected in advance by the secretary of state.

B. The following fees and licenses shall be collected in advance by the commissioner of insurance:

<COL> (1)<COL>Fee to accompany application for initial certificate of authority, insurer, and rating organization<COL>$<COL>2,500.00<COL>

<COL> (2)<COL>An annual financial regulation fee from every health maintenance organization, domestic and foreign company, vehicle mechanical breakdown insurer, and property residual value insurer for examination and analysis of its financial condition<COL>$<COL>1,000.00<COL>

<COL> (3)<COL>For producers' licenses:<COL><COL><COL>

<COL> <COL>(a)<COL>Life, health, and accident producer; variable annuity producer<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>75.00<COL>

<COL><COL><COL>Additional or renewal company appointment (yearly)<COL>$<COL>20.00<COL>

<COL><COL><COL>Producer renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(b)<COL>Property and casualty producer:<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>75.00<COL>

<COL><COL><COL>Additional or renewal company appointment (yearly)<COL>$<COL>20.00<COL>

<COL><COL><COL>Producer renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(c)<COL>Limited lines producer<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>75.00<COL>

<COL><COL><COL>Each additional line of authority<COL>$<COL>35.00<COL>

<COL><COL><COL>Additional or renewal company appointment (yearly)<COL>$<COL>20.00<COL>

<COL><COL><COL>Renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(d)<COL>Limited lines credit insurance producer<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>75.00<COL>

<COL><COL><COL>Additional or renewal company appointment (yearly)<COL>$<COL>20.00<COL>

<COL><COL><COL>Renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(e)<COL>Surplus lines broker<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>250.00<COL>

<COL><COL><COL>Renewal fee (every two years)<COL>$<COL>350.00<COL>

<COL><COL>(f)<COL>Fee for failure to file producer license renewal timely (per license)<COL>$<COL>50.00<COL>

<COL><COL>(g)<COL>Fee for duplicate producer license<COL>$<COL>15.00<COL>

<COL> (4)<COL>For certified copies of any documents, per page<COL>$<COL>.25<COL>

<COL> (5)<COL>Repealed by Acts 2007, No. 404, § 2.<COL><COL><COL>

<COL> (6)<COL>For securities fees<COL><COL><COL>

<COL><COL>Registration of securities<COL>$<COL>200.00<COL>

<COL><COL>Registration of securities dealer<COL>$<COL>50.00<COL>

<COL><COL>Registration of securities salesman<COL>$<COL>10.00<COL>

<COL> (7)<COL>Repealed by Acts 2001, No. 460, § 2, effective January 1, 2002<COL><COL><COL>

<COL> (8)<COL>For filing a charter, other documents, and amendments thereto<COL>$<COL>25.00<COL>

<COL> (9)<COL>For each company filing of self-insured health and accident insurance policy forms, per product<COL>$<COL>100.00<COL>

<COL>(10)<COL>(a)<COL>For each company filing of property and casualty insurance policy forms, per product<COL>$<COL>100.00<COL>

<COL><COL>(b)<COL>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)<COL>$<COL>20.00<COL>

<COL><COL>(c)<COL>For each company filing of property and casualty insurance policy endorsements, amendments, or riders<COL>$<COL>25.00<COL>

<COL>(11)<COL>(a)<COL>For each company filing of life, health, and accident insurance policy forms or health maintenance organization subscriber agreements, per product<COL>$<COL>100.00<COL>

<COL><COL>(b)<COL>For each company filing of Medicare supplement insurance premium rates, rating schedule, and supporting documentation, per type of standard benefit plan<COL>$<COL>100.00<COL>

<COL><COL>(c)<COL>For each company filing of Medicare supplement insurance advertisements, per submission<COL>$<COL>100.00<COL>

<COL>(12)<COL>For certification of a self-insured workers' compensation insurance program, an initial certification fee<COL>$<COL>1,500.00<COL>

<COL>(13)<COL>For review of a self-insured workers' compensation insurance program, an annual review fee<COL>$<COL>300.00<COL>

<COL>(14)<COL>Managing general agents<COL><COL>

<COL> <COL>(a)<COL>Initial registration<COL>$<COL>300.00<COL>

<COL><COL>(b)<COL>Annual registration<COL>$<COL>300.00<COL>

<COL><COL>(c)<COL>Insurer's initial notice of appointment<COL>$<COL>300.00<COL>

<COL><COL>(d)<COL>Insurer's annual notice of appointment<COL>$<COL>300.00<COL>

<COL>(15)<COL>Third party administrators<COL><COL><COL>

<COL> <COL>(a)<COL>Licensing fee<COL>$<COL>500.00<COL>

<COL><COL>(b)<COL>Annual report filing fee<COL>$<COL>300.00<COL>

<COL>(16)<COL>Fee to accompany the statement required in an acquisition of control or merger with a domestic insurer<COL>$<COL>2,500.00<COL>

<COL>(17)<COL>Approval of foreign or alien surplus lines insurers<COL>$<COL>1,050.00<COL>

<COL>(18)<COL>(a)<COL>Registration of a risk purchasing group<COL>$<COL>100.00<COL>

<COL><COL>(b)<COL>Annual renewal of registration for a risk purchasing group<COL>$<COL>50.00<COL>

<COL>(19)<COL>For viatical settlement licenses:<COL><COL><COL>

<COL> <COL>(a)<COL>Viatical settlement broker:<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>50.00<COL>

<COL><COL><COL>Annual renewal<COL>$<COL>50.00<COL>

<COL><COL>(b)<COL>Viatical settlement investment agent:<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>50.00<COL>

<COL><COL><COL>Annual renewal<COL>$<COL>50.00<COL>

<COL><COL>(c)<COL>Viatical settlement provider<COL>$<COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>1,000.00<COL>

<COL>(20)<COL>For filing viatical settlement contracts, disclosure notices, and advertising materials, per filing:<COL>$<COL>100.00<COL>

<COL>(21)<COL>For the initial registration of a risk retention group<COL>$<COL>1,000.00<COL>

<COL>(22)<COL>For acceptance of service of process when the commissioner is appointed as agent for a nonresident licensee or a foreign or alien entity<COL>$<COL>25.00<COL>

<COL>(23)<COL>For claims adjuster licenses and registrations:<COL><COL><COL>

<COL> <COL>(a)<COL>Business entity<COL><COL><COL>

<COL><COL><COL> First time applicant<COL>$<COL>55.00<COL>

<COL><COL><COL> Renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(b)<COL>Resident and nonresident<COL><COL><COL>

<COL><COL><COL> First time applicant<COL>$<COL>55.00<COL>

<COL><COL><COL> Renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(c)<COL>Catastrophe and emergency claims adjuster<COL>$<COL>25.00<COL>

<COL>(24)<COL>For public adjuster licenses:<COL><COL><COL>

<COL> <COL>(a)<COL>Business entity<COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>55.00<COL>

<COL><COL><COL>Renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL><COL>(b)<COL>Resident and nonresident<COL><COL><COL>

<COL><COL><COL>First time applicant<COL>$<COL>55.00<COL>

<COL><COL><COL>Renewal fee (every two years)<COL>$<COL>50.00<COL>

<COL>(25)<COL>For a certificate of compliance<COL>$<COL>10.00<COL>

<COL>(26)<COL>For each filing of vehicle mechanical breakdown insurance policies, per submission<COL>$<COL>25.00<COL>

<COL>(27)<COL>For each filing of property residual value insurance policies, per submission<COL>$<COL>25.00<COL>

<COL>(28)<COL>Repealed by Acts 2013, No. 326, § 2, eff. Jan. 1, 2015.<COL><COL><COL>

<COL>(29)<COL>For prelicensing or continuing education:<COL><COL><COL>

<COL><COL>(a)<COL>Provider application<COL>$<COL>250.00<COL>

<COL><COL>(b)<COL>Program or course application, per program or course<COL>$<COL>25.00<COL>

<COL>(30)<COL>Repealed by Acts 2015, No. 161, § 2, eff. Jan. 11, 2016.<COL><COL><COL>

<COL>(31)<COL>Fee for application for insurance producer for specialty limited lines credit insurance.<COL><COL><COL>

<COL><COL>(a)<COL>Initial application if registering twenty or fewer employees<COL>$<COL>250.00<COL>

<COL><COL>(b)<COL>Initial application if registering twenty-one or more employees<COL>$<COL>1,000.00<COL>

<COL><COL>(c)<COL>Annual renewal fee if registering twenty or fewer

employees<COL>$<COL>125.00<COL>

<COL><COL>(d)<COL>Annual renewal fee if registering twenty-one or more employees<COL>$<COL>500.00<COL>

<COL>(32)<COL>Fee for application for insurance producer for specialty limited lines motor vehicle title insurance line.<COL><COL><COL>

<COL><COL>(a)<COL>Initial application if registering twenty or fewer employees<COL>$<COL>250.00<COL>

<COL><COL>(b)<COL>Initial application if registering twenty-one or more employees<COL>$<COL>1,000.00<COL>

<COL><COL>(c)<COL>Fee for registration of employees, per employee up to twenty-five hundred dollars<COL>$<COL>20.00<COL>

<COL><COL>(d)<COL>Annual renewal fee if registering twenty or fewer employees<COL>$<COL>125.00<COL>

<COL><COL>(e)<COL>Annual renewal fee if registering twenty-one or more employees<COL>$<COL>500.00<COL>

<COL>(33)<COL>Motor vehicle rental insurers.

<COL><COL>(a)<COL>Initial license application:<COL><COL><COL>

<COL> <COL><COL>(i)<COL>Twenty-six or more vehicles<COL>$<COL>500.00<COL>

<COL><COL><COL>(ii)<COL>Twenty-five or fewer vehicles<COL>$<COL>100.00<COL>

<COL><COL>(b)<COL>Renewal<COL><COL>

<COL> <COL><COL>(i)<COL>Twenty-six or more vehicles<COL>$<COL>250.00<COL>

<COL><COL><COL>(ii)<COL>Twenty-five or fewer vehicles<COL>$<COL>50.00<COL>

<COL>(34)<COL>For appraisers:

<COL><COL>First time applicant<COL>$<COL>55.00<COL>

<COL><COL>Renewal fee (every twelve months)<COL>$<COL>50.00<COL>

<COL>(35)<COL>Portable Electronics Insurance Limited Lines License<COL><COL><COL>

<COL><COL>(a)<COL>Initial license application<COL>$<COL>200<COL>

<COL><COL>(b)<COL>Renewal<COL>$<COL>100<COL>

<COL>(36)<COL>Utilization review organization other than a health insurance issuer<COL><COL><COL>

<COL><COL>(a)<COL>Application fee<COL>$<COL>1,500.00 <COL>

<COL><COL>(b)<COL>Annual report filing fee<COL>$<COL>500.00<COL>

<COL>(37)<COL>Independent review organization<COL><COL><COL>

<COL><COL>(a)<COL>Application fee<COL>$<COL>500.00 <COL>

<COL><COL>(b)<COL>Annual report filing fee<COL>$<COL>500.00<COL>

C. The commissioner of insurance is authorized to withhold the funds collected under Subparagraph (B)(3)(g) 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 examination of insurers pursuant to Chapter 8 of this Title and processing of the annual reports and premium tax forms as required by R.S. 22:571 and R.S. 22:792 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 Paragraph (B)(3) 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 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 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, R.S. 49:950 et seq.

Renumbered from R.S. 22:1078 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. 18, § 1; Acts 1983, 1st Ex.Sess., No. 25, § 1, eff. Mar. 1, 1983; Acts 1992, No. 381, § 1; Acts 1992, No. 1135, § 1; Acts 1993, No. 295, § 1; Acts 1999, No. 299, § 1, eff. June 11, 1999; Acts 1999, No. 342, § 6; Acts 1999, No. 912, § 1, eff. Jan. 1, 2000; Acts 2001, No. 460, § 1, eff. Jan. 1, 2002; Acts 2002, 1st Ex.Sess., No. 87, § 1; Acts 2003, No. 343, § 1; Acts 2004, No. 376, § 1; Acts 2006, No. 385, § 1, eff. June 15, 2006; Acts 2006, No. 762, § 1, eff. June 30, 2006; Acts 2006, No. 763, § 1, eff. June 30, 2006; Acts 2007, No. 191, § 1, eff. July 1, 2007; Acts 2007, No. 404, § 1; Acts 2008, No. 208, § 1; Acts 2008, No. 818, § 1; Acts 2008, No. 883, § 1; Acts 2009, No. 33, § 1; Acts 2009, No. 34, § 1; Acts 2009, No. 94, § 1, eff. Jan. 1, 2010; Acts 2009, No. 95, § 1; Acts 2009, No. 101, § 1, eff. Jan. 1, 2010; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2012, No. 56, § 1; Acts 2012, No. 96, § 1; Acts 2012, No. 311, § 1; Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 822. 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 three 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 accept only 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.

Renumbered from R.S. 22:1065.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 834, § 5, eff. June 22, 1993. Amended by Acts 1999, No. 717, § 2; Acts 1999, No. 1080, § 1, eff. July 9, 1999; Acts 2000, 1st Ex.Sess., No. 113, § 1; Acts 2001, No. 928, § 2, eff. June 26, 2001; Acts 2005, No. 350, § 1; Acts 2012, No. 361, § 1.

PART IV. TAXES AND EXEMPTIONS

§ 831. 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 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 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 tax, and the amount of the tax shall be based on the combined gross annual premiums of all such businesses.

(2) This tax shall be paid on a quarterly basis.

B. 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 and for special law enforcement initiatives. 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 Constitution of Louisiana, 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.

Renumbered from R.S. 22:1065 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1974, No. 42, § 2; Acts 1984, 1st Ex.Sess., No. 3, § 1, eff. March 27, 1984; Acts 2002, No. 83, § 1, eff. June 30, 2002; Acts 2009, No. 503, § 1; Acts 2014, No. 524, § 3.

§ 832. Reduction of tax when certain investments are made in Louisiana

A. The amount of the tax 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 the end of each fiscal quarter 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 of this Section. The amount of tax credit granted shall be the average of the percentage of qualifying Louisiana securities held at the end of each fiscal quarter for the fiscal year.

B. If one-sixth of the total admitted assets of the payer are in qualifying Louisiana investments, then the tax 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 tax 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 tax 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 tax 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:

(1) Certificates of deposit issued in Louisiana by any bank or savings and loan association or savings bank, any of which are operating in the state of Louisiana or a trust company operating in the state of Louisiana with a main office or one or more branches where the trust company holds such funds in trust and invests them in certificates of deposit issued by a bank, savings and loan association or savings bank operating in the state of Louisiana with a main office or one or more branches.

(2) 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;

(3) Mortgages on property located in this state;

(4) Real property located in this state;

(5) Policy loans to residents of Louisiana, or other loans to residents of this state, or to corporations domiciled in this state;

(6) Common or preferred stock in corporations domiciled in this state; and

(7) Cash on deposit in an account in Louisiana in any bank or savings and loan association, or savings bank, or trust company holding such funds in trust, operating in the state of Louisiana with a main office or one or more branches.

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. 22:439, 831, 836, 838, and 842. 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. 22:345, 833, 834, 835, 837, and 1476. 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).

Renumbered from R.S. 22:1068 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2006, No. 587, § 1; Acts 2009, No. 478, § 2, eff. July 1, 2010; Acts 2009, No. 503, § 1.

§ 833. Authorization of local taxes; penalties for nonpayment

A. Any municipal or parochial corporation in the state shall have the right to impose a 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 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 tax 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. However, the maximum tax on such businesses, payable to such municipal or parochial corporation by any one insurer, shall not exceed twenty-one thousand dollars. Premiums paid to an insurer by Louisiana Medicaid programs shall be exempt from the tax imposed by this Section.

(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, workers' compensation, employers' liability, property damage, livestock, vehicle, automatic sprinkler, burglary, or insurance business of any other kind whatsoever in this state, whether such insurer is operating in this state through producers 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 tax 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 tax 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 tax shall not exceed eighty dollars;

(d) 4th Class: When the gross receipts exceed six thousand dollars, the additional tax 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 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) of this Section.

(2) The amount of tax 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. 22:832(C).

(3) The total 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 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 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, may revoke the authority of the taxpayer and all the taxpayer's agents to do business in this state.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

E. For a municipal or parochial corporation which has not imposed a tax pursuant to this Section on or before August 15, 2012, the authorization for such tax shall cease effective August 16, 2012. However, a municipal or parochial corporation which imposed a tax pursuant to this Section on or before August 15, 2012, shall retain the authority to renew that existing tax so long as such renewal does not exceed the limit provided in this Subpart.

Renumbered from R.S. 22:1076 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by 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; Acts 2009, No. 317, § 1; Acts 2009, No. 503, § 1; Acts 2012, No. 774, § 1, eff. July 1, 2012.

§ 834. Local taxes; contracts for collection; confidentiality of records

A. The taxes authorized by the provisions of R.S. 22:833 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 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 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.

Renumbered from R.S. 22:1076.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 799, § 1, eff. June 26, 2001. Amended by Acts 2009, No. 503, § 1.

§ 835. 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 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 of this Section 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 of this Section 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 of this Section 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.

F. Each year, after satisfaction of the provisions of Subsections C and D of this Section, and before any unexpended or unencumbered monies in the Louisiana Fire Marshal Fund shall revert to the state general fund, the state treasurer shall transfer the amount of fifty thousand dollars to the Camp Minden Fire Protection Fund as provided by R.S. 22:835.1.

Renumbered from R.S. 22:1077 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 416, § 1. Amended by 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; Acts 2009, No. 503, § 1; Acts 2012, No. 546, § 1, eff. June 30, 2012.

§ 835.1. Camp Minden Fire Protection Fund

A. There is hereby created in the state treasury, as a special fund, the Camp Minden Fire Protection Fund, hereinafter referred to as the "fund". Annually, the state treasurer shall transfer monies into the fund in accordance with the provisions of R.S. 22:835(F). Subject to appropriation by the legislature, monies in the fund shall be used solely to provide fire protection at the National Guard Installation at Camp Minden, to be used to contract with an independent fire district to provide for fire protection for Camp Minden. Such contract shall be between the independent fire district and the Louisiana National Guard.

B. All unexpended and unencumbered monies in the fund at the end of each fiscal year shall remain in the fund. The monies in the 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 the state general fund.

Added by Acts 2012, No. 546, § 1, eff. June 30, 2012.

§ 836. 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 R.S. 22:333(C). Assessments by insurance guaranty associations or similar organizations are not considered in determining retaliatory taxation.

Renumbered from R.S. 22:1079 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1970, No. 84, § 1; Acts 2001, No. 460, § 1, eff. Jan. 1, 2002.

§ 837. 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 thirty-first 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 thirty-first. 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 thirty-first 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.

Renumbered from R.S. 22:1080 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 32, § 1. Amended by Acts 1984, No. 229, § 1; Acts 1991, No. 1014, § 1, eff. July 1, 1991.

§ 838. Imposition of tax; exceptions

A. There is hereby levied an annual tax on each admitted 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 tax 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 tax levied by the provisions of this Section.

Renumbered from R.S. 22:1061 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 503, § 1.

§ 839. Certain nonprofit mutual associations declared charitable institutions

Any domestic nonprofit 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 nonprofit 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 subdivisions, taxes on the real estate and the office equipment owned by the association, and the fee provided for in R.S. 22:840. 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.

Renumbered from R.S. 22:1661 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 840. Fee; filing of charter and bylaws and annual affidavit; certificate

Any association of the type described in R.S. 22:839 which desires to take advantage of the tax exemption granted therein shall pay an annual fee of two hundred fifty dollars to the commissioner of insurance and shall furnish him with a certified copy of its charter and bylaws 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 nonprofit hospitals or medical societies which a majority of the directors represent. Upon payment of the 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, fees, or assessments due to the state or to any of its political subdivisions, except the payment of the annual fee of two hundred fifty dollars.

Renumbered from R.S. 22:1662 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 503, § 1.

§ 841. Policy provisions

No insurer which takes advantage of the provisions of R.S. 22:839 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.

Renumbered from R.S. 22:1663 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 842. 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 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 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 tax, and the amount of the tax shall be based on the combined gross annual premiums of all such businesses.

B. Taxes collected under the provision of this Section from health care premium assessments paid by Medicaid-enrolled managed care organizations, after first having been credited to the Bond Security and Redemption Fund as required by Article VII, Section 9(B) of the Constitution of Louisiana, shall be deposited into the Louisiana Medical Assistance Trust Fund.

Renumbered from R.S. 22:1062 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1982, No. 868, § 1, eff. Jan. 1, 1982; Acts 1984, 1st Ex.Sess., No. 3, § 1, eff. March 27, 1984; Acts 2009, No. 503, § 1. Amended by Acts 2012, No. 597, § 1, eff. June 7, 2012.

§ 843. 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.

Renumbered from R.S. 22:1066 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1982, No. 868, § 1, eff. Jan. 1, 1982.

§ 844. 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 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 first 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. 22:341, at year end, the 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 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 tax as provided in this Part.

Renumbered from R.S. 22:1067 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1966, No. 173, § 1; Acts 1983, 1st Ex.Sess., No. 16, § 1, eff. Jan. 19, 1983; Acts 2009, No. 503, § 1.

§ 845. Payment of tax

The 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 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 taxes levied under the provisions of this Part.

Renumbered from R.S. 22:1071 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 175, § 1; Acts 1983, 1st Ex.Sess., No. 16, § 1, eff. Jan. 19, 1983; Acts 1984, 1st Ex.Sess., No. 3, § 1, eff. March 27, 1984; Acts 1991, No. 10, § 1, eff. June 10, 1991; Acts 2009, No. 503, § 1.

§ 846. 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 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 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 tax paid, the commissioner of insurance shall revoke the authority of the delinquent taxpayer, and of all of said taxpayer's producers 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.

Renumbered from R.S. 22:1072 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1984, No. 500, § 1; Acts 1997, No. 523, § 1; Acts 2001, No. 166, § 1, eff. January 1, 2002; Acts 2009, No. 503, § 1.

§§ 847 to 850. Reserved for future legislation

CHAPTER 4. INSURANCE AND INSURANCE CONTRACT REQUIREMENTS BY TYPE OF INSURANCE

PART I. INSURANCE AND POLICY REQUIREMENTS IN GENERAL

§ 851. Scope of Chapter

A. The applicable provisions of this Chapter shall apply to insurance other than ocean marine and foreign trade insurances. This Chapter shall not apply to life insurance policies or annuities not issued for delivery in this state nor delivered in this state. This Chapter 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 where it was issued or delivered.

B. The exceptions in Subsection A of this Section do not apply to R.S. 22:855. The only exceptions from the requirements of R.S. 22:855 are those specifically stated therein.

Renumbered from R.S. 22:611 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1983, No. 188, § 1; Acts 1989, No. 563, § 1, eff. Sept. 1, 1989; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011; Acts 2012, No. 271, § 1.

§ 852. 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, void, 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.

Renumbered from R.S. 22:612 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 853. 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 Chapter 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.

Renumbered from R.S. 22:614 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 854. Interest of the insured

A. 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, annuity, or health and accident insurance.

B. With regard to loss by fire, the wrongful or malicious actions of a named insured that are determined to be the cause of the loss to the insured property shall not be imputed to any other insured such that the innocent insured would be deprived of coverage provided by the policy. In case of a fire that is set intentionally, the policy proceeds may only be reduced by the proper interest attributable to the insured that set the fire or otherwise participated in the cause of the loss. In the case of multiple named insureds, an innocent insured shall receive his proportionate share of the policy proceeds.

Renumbered from R.S. 22:615 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2007, No. 156, § 1, eff. June 25, 2007; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 855. 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, producer 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 producer, and except for an agency fee, if any, as authorized hereunder.

(2)(a) The producer may receive reimbursement from the insured for expenses incurred by the producer directly related to the insurance coverage for the insured. In addition, the producer may charge a reasonable agency fee related to the services provided by the producer. 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, homeowners insurance, 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) of this Section.

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) of this Subsection 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) Upon making a written finding that an amount in excess of the quoted premium has been received, the commissioner 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 a producer's license.

(3) A revocation of an insurer's certificate of authority or a producer's license.

H. The provisions of this Section shall apply to all policies except life, annuity, and reinsurance policies.

Renumbered from R.S. 22:627 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by 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, No. 135, § 1; Acts 1999, No. 551, § 1; Acts 2004, No. 466, § 1, eff. Jan. 1, 2005; Acts 2009, No. 317, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011; Acts 2013, No. 283, § 1, eff. June 14, 2013.

§ 856. Application for insurance required

No life, annuity, 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.

Renumbered from R.S. 22:616 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 857. Application as evidence; life, annuity, or health and accident insurance

A. No application for life, annuity, 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. 22:149(2) and 975(A)(1).

B. If any policy of life, annuity, 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.

Renumbered from R.S. 22:618 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 98, § 1. Amended by Acts 1989, No. 573, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 858. 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.

Renumbered from R.S. 22:616.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 732, § 1.

§ 859. 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.

Renumbered from R.S. 22:617 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 860. Warranties and misrepresentations in negotiation; applications

A. Except as provided in Subsection B of this Section, R.S. 22:1314, and 1315, 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, annuity, 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 either one of the following is true as to the applicant's statement:

(1) The false statement was made with actual intent to deceive.

(2) The false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer under the policy.

Renumbered from R.S. 22:619 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1985, No. 506, § 1; Acts 2008, No. 454, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 861. Approval of forms

A. (1) No basic insurance policy form, other than fidelity or 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, annuity, 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 forty-five-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 issued by the commissioner.

Renumbered from R.S. 22:620 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 862. 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 previously 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 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.

Renumbered from R.S. 22:621 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1991, No. 518, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 863. 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 Subpart C of Part IV of this Chapter in a particular insurance contract form if both of the following apply:

(1) The commissioner finds such provision unnecessary for the protection of the insured and inconsistent with the purposes of the contract.

(2) The contract is otherwise approved by the commissioner.

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 Subpart C of Part IV of Chapter 4 of this Title, 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.

Renumbered from R.S. 22:623 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 864. 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 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, annuity, 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 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 less than ten-point type. The text 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 provided any policy examining bureau having jurisdiction or to the insured upon request.

D. This Section shall not apply to fidelity or surety insurance contracts.

Renumbered from R.S. 22:624 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 1989, No. 697, § 1; Acts 1999, No. 1312, § 1, eff. July 12, 1999; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 865. Additional contents

A policy may contain additional provisions, which are not inconsistent with this Code, and which are either:

(1) Required to be inserted by the laws of the insurer's state of domicile.

(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.

Renumbered from R.S. 22:625 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 866. Articles of incorporation; bylaw provisions

No policy shall contain any provision purporting to make any portion of the articles of incorporation, bylaws, 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.

Renumbered from R.S. 22:626 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 867. Must contain entire contract with exceptions

A. 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 Subpart C of Part IV of this Chapter.

B. 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 or issued thereafter.

C. 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, by electronic transaction in accordance with the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq., or is personally delivered to such holder.

Renumbered from R.S. 22:628 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011; Acts 2011, No. 373, § 1.

§ 868. 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 either:

(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.

B. 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 health and accident policy insuring a resident of this state regardless of where made or delivered, shall contain any condition, stipulation, or agreement limiting right of action against the insurer to a period of less than twenty-four months next after the inception of the loss when the claim is a first-party claim, as defined in R.S. 22:1692, and arises under any insurance classified and defined in R.S. 22:47(6), (10), (11), (12), (13), (15), and (19) 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.

C. 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.

Renumbered from R.S. 22:629 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1983, No. 188, § 1; Acts 1987, No. 210, § 1, eff. July 2, 1987; Acts 2006, No. 739, § 1, eff. June 29, 2006; Acts 2007, No. 43, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

Declaratory Judgment Action; Validity—Acts 2006, No. 739

Section 3 of Acts 2006, No. 739 (§ 1 of which amended this section and enacted R.S. 22:658.3 [Act 739 did not contain a § 2]) provided:

"Section 3. The attorney general is hereby directed to file suit within ten days of the effective date of this Act seeking declaratory judgment to determine the constitutionality of the provisions of this Act or the constitutionality of Acts 2006, No. __ that originated as House Bill No. 1302 or Acts 2006, No.__ that originated as Senate Bill No. 740, and such suit shall seek to determine the constitutionality of any or all of these Acts."

House Bill No. 1302 was enacted and designated Acts 2006, No. 802, providing for the interruption of prescription for Hurricane Katrina and Hurricane Rita insurance claims. Senate Bill No. 740 did not become law.

For provisions of Acts 2006, No. 802, see C.C. art. 3467 in L.S.A.

In the case of State of Louisiana v. All Property and Casualty Insurance Carriers Authorized and Licensed to do Business in the State of Louisiana, 937 So.2d 313 (La. 8/25/06), the Louisiana Supreme Court, exercising its supervisory authority in an expedited manner to determine the validity of Acts 2006, Nos. 739 and 802, declared them both to be constitutional.

§ 869. 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.

Renumbered from R.S. 22:630 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 870. 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.

Renumbered from R.S. 22:631 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 173, § 1.

§ 871. Signature of producer

Every duly licensed producer 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 producer shall sign any application described above unless he personally obtained the information shown on such application. Such information may be obtained by the producer in person, by telephone, or by any other means of direct communication between the producer and the applicant.

Renumbered from R.S. 22:1460 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 178, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2003, No. 410, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 872. 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.

Renumbered from R.S. 22:633 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 873. 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. Delivery may be by the United States Postal Service, personal delivery, private courier, or by electronic transaction in accordance with the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq.

B. In the 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. Delivery may be by the United States Postal Service, personal delivery, private courier, or by electronic transaction in accordance with the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq.

Renumbered from R.S. 22:634 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 373, § 1.

§ 874. 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.

Renumbered from R.S. 22:640 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 875. 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 void the contract nor allow the insurer to avoid liability, unless the breach is material and exists at the time of the loss.

Renumbered from R.S. 22:641 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 876. Assignment of policies

Subject to the terms of the policy relating to its assignment, life insurance policies, other than group life insurance policies, annuity, and health and accident policies providing benefits for accidental death, 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.

Renumbered from R.S. 22:642 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1966, No. 237, § 1; Acts 2003, No. 124, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 877. 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 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.

Renumbered from R.S. 22:643 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 878. Forms for proof of loss furnished

Any insurer requiring completion of a proof of loss form shall provide such form to any person claiming to have a loss under any insurance contract; however, such insurer shall not, by reason of the requirement to provide forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

Renumbered from R.S. 22:650 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2003, No. 137, § 1, eff. Jan. 1, 2004; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 879. 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:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy.

(2) Providing 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 considering a possible settlement of any such loss or claim.

Renumbered from R.S. 22:651 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 880. 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, 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.

Renumbered from R.S. 22:653 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 881. 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.

Renumbered from R.S. 22:654 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125.

§ 881.1. Redesignated as R.S. 22:890 by Acts 2010, No. 375, § 2, eff. Jan. 1, 2011

§ 882. 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.

(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.

Renumbered from R.S. 22:666 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1974, No. 435, § 1. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 883. 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. 22:1061(1), shall be submitted to the Department of Insurance for prior approval pursuant to the policy form filing requirements established by R.S. 22:861 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 groups of fifty or fewer shall be, at a minimum, one hundred twenty percent of the group health plan's total expected claims per policy period. The aggregate stop-loss or excess limit or attachment point for groups of fifty-one or more shall be, at a minimum, one hundred ten 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. 22:1269(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 (b) of this Paragraph 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 (b) of this Paragraph 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. 22:452(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. 22:452(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.

Renumbered from R.S. 22:675 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 273, § 1, eff. June 1, 2001. Amended by Acts 2003, No. 140,

§ 1; Acts 2007, No. 80, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 884. 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.

Renumbered from R.S. 22:172 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 885. Cancellation by the insured; surrender

A. Cancellation by the insured of any policy which by its terms may be cancelled 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 the event the policy or binder has been lost or destroyed and cannot be 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 pro rata rate, unless otherwise stated in a policy that has been filed with and approved by the commissioner, and any unearned commission. 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. Except for surplus line insurers, any assessment of a monetary penalty by an insurer against an insured as a result of the insured's cancellation prior to the expiration of any policy is prohibited. Nothing in this Section shall prohibit an insurer from calculating unearned premium based on a short-rate provision contained in any insurance policy that has been filed with and approved by the commissioner.

C. The surrender of a policy to the insurer for any cause by any person named therein as having an interest insured under the policy shall create a presumption that such surrender is agreed to by all persons so named.

D. This Section shall not apply to life insurance policies, annuity contracts, policies defined in R.S. 22:47(16)(b), or contracts provided for in Subpart C of Part IV of this Chapter.

E. With respect to the cancellation of liability automobile insurance, the office of motor vehicles shall not assess the fees set forth by R.S. 32:863(A)(3)(a) when the insured surrenders the license plate of the uninsured vehicle to the office of motor vehicles within ten calendar days from the date of notice prescribed by R.S. 32:863.2(E).

Renumbered from R.S. 22:637 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1991, No. 739, § 1; Acts 1991, No. 790, § 1; Acts 1997, No. 1428, § 1; Acts 2010, No. 169, § 1; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011. Amended by Acts 2011, No. 21, § 1; Acts 2011, No. 135, § 1;

Acts 2011, No. 370, § 1.

§ 886. 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 cannot be cancelled by the insurer and the insured did not knowingly participate in any such violation.

Renumbered from R.S. 22:638 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 887. Cancellation by insurer; changes to homeowner's insurance policies

A. Cancellation by the insurer of any policy which by its terms may be cancelled 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 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 and no cause of action shall arise against any insurer or its producers, 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. 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) When the policy is a homeowner's insurance policy, like notice shall be provided of any cancellation, or if, at the personal request of the insured, any such person is removed from the policy or substituted with another as provided in Subsection A of this Section.

(5) 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. 22:1460(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, 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, annuity, 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 Subpart C of Part IV 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. (1) 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.

(2) Like notice shall also be 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. For purposes of this Paragraph, "delivered" includes electronic transmittal, facsimile, or personal delivery.

(3) This Subsection shall not apply:

(a) To policies regulated by R.S. 22:1266 and 1267.

(b) 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.

(c) In the case of nonpayment of the premium.

(d) If the named insured has provided written notification to the insurer of the insured's intention to not renew the policy.

(e) 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 producer shall not be required to give any separate or additional notice of cancellation or nonrenewal.

I. Any insurer that issues notice of cancellation on an insurance policy that provides coverage on any property and later continues or reinstates that insurance policy shall issue notice of reinstatement to every policyholder, insurance producer, mortgagee, lienholder, pledgee, or other known person shown by the policy to have an interest in any loss which may occur thereunder and who received the notice of cancellation.

Renumbered from R.S. 22:636 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by 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; Acts 2006, No. 345, § 1; Acts 2009, No. 333, § 1, eff. April 1, 2010; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011; Acts 2010, No. 1016, § 2; Acts 2012, No. 198, § 1.

§ 888. 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 date 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 and no cause of action against any insurer or its producers, 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.

(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 Postal Service. 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, check, bank draft, or money order.

Renumbered from R.S. 22:636.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2010, No. 375, § 1, eff. Jan. 1, 2011.

§ 889. 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. 22:2011.

Renumbered from R.S. 22:636.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 697, § 1.

§ 890. Certificates of insurance

A. For the purposes of this Section:

(1) "Certificate" or "certificate of insurance" means any document, instrument, or record, including an electronic record, no matter how titled or described, which is prepared by an insurer or insurance producer and issued to a third person not a party to the subject insurance contract, as evidence of property and casualty insurance coverage. "Certificate" or "certificate of insurance" shall not mean an insurance binder.

(2) "Certificate holder" means any person, other than a policyholder, that is designated on a certificate of insurance as a "certificate holder" or any person, other than a policyholder, to whom a certificate of insurance has been issued by an insurer or insurance producer at the request of the policyholder.

(3) "Electronic record" shall have the meaning defined in R.S. 9:2602(7).

(4) "Insurance" shall have the meaning defined in R.S. 22:46(9).

(5) "Insurance producer" shall have the same definition as set forth in R.S. 22:1542.

(6) "Insurer" means an insurer as defined in R.S. 22:46(10) and any other person engaged in the business of making property and casualty insurance contracts, including but not limited to self-insurers, syndicates, risk purchasing groups, and similar risk transfer entities. "Insurer" shall not mean any person self-insured for purposes of workers' compensation, including any group self-insurance fund authorized pursuant to R.S. 23:1195 et seq., any interlocal risk management agency authorized pursuant to R.S. 33:1341 et seq., or any self-insured employer authorized pursuant to R.S. 23:1168 et seq.

(7) "Person" means any individual, company, insurer, organization, reciprocal or inter-insurance exchange, business, partnership, corporation, limited liability company, association, trust, or other legal entity, including any government or governmental subdivision or agency.

(8) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

(9) "Record" shall have the meaning defined in R.S. 9:2602(13).

(10) "Self-insurer" means any individual business or group of businesses which have created a risk purchasing group, risk retention plan, syndicate, or other form of self-insurance covering property or casualty risk exposures. "Self-insurer" shall not mean any person self-insured for purposes of workers' compensation, including any group self-insurance fund authorized pursuant to R.S. 23:1195 et seq., any interlocal risk management agency authorized pursuant to R.S. 33:1341 et seq., or any self-insured employer authorized pursuant to R.S. 23:1168 et seq.

B. No property or casualty insurer or insurance producer may issue a certificate of insurance or any other type of document purporting to be a certificate of insurance that will affirmatively or negatively alter, amend, or extend the coverage provided by the referenced insurance policy. A certificate of insurance shall also not convey any contractual rights to the certificate holder.

C. No person, wherever located, may prepare, issue, or request the issuance of a certificate of insurance for risks located in this state unless the form has been filed with and approved by the commissioner of insurance. No person, wherever located, may alter or modify an approved certificate of insurance form unless the alteration or modification has been approved by the commissioner of insurance.

D. The commissioner of insurance shall disapprove a form filed under this Section or withdraw approval of a form if that form:

(1) Is unfair, misleading, or deceptive, or violates public policy.

(2) Violates any state statute or regulation validly promulgated by the commissioner of insurance.

(3) Requires certification of insurance coverages that are not available.

E. The commissioner may approve a certificate of insurance form that does not

state that the form is provided for information only or similar language, provided that the form states that the certificate of insurance does not confer any rights or obligations other than those conveyed by the policy and that the terms of the policy control. Further, use of such a form shall not be, in and of itself, cause for disapproval by the commissioner under the provisions of Subsection D of this Section.

F. (1) The commissioner of insurance shall approve or disapprove certificate of insurance forms filed pursuant to this Section in writing within forty-five days of receipt of the form.

(2) Standard certificate of insurance forms promulgated by the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), or the Insurance Services Office (ISO) shall be filed, but are deemed approved by the commissioner of insurance, provided these forms comply with the provisions of this Section.

G. No person shall demand or request the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

H. No person may prepare, issue, or request, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence, instrument, or record, including an electronic record, that is inconsistent with this Section; however, an insurer or insurance producer may prepare or issue an addendum that clarifies, explains, summarizes, or provides a statement of the coverages provided by a policy of insurance and otherwise complies with the requirements of this Section.

I. The provisions of this Section shall apply to all certificate holders, policyholders, insurers, insurance producers, and certificate of insurance forms issued as a statement or evidence of insurance coverages on property, operations, or risks located in this state, regardless of where the certificate holder, policyholder, insurer, or insurance producer is located.

J. A certificate of insurance form which has been approved by the commissioner and properly executed and issued by a property and casualty insurer or an insurance producer, shall constitute a confirmation that the referenced insurance policy has been issued or that coverage has been bound notwithstanding the inclusion of "for information purposes only" or similar language on the face of the certificate. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy or any validly executed endorsements of insurance provides.

K. No certificate of insurance shall contain references to legal or insurance requirements contained in any contracts other than the underlying contracts of insurance, including construction or service contracts.

L. A person shall have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance only

if the person is named within the policy or any endorsement and the policy or endorsement, law, or regulation of this state requires notice to be provided. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance in accordance with the laws and regulations of this state and cannot be altered by a certificate of insurance.

M. Any certificate of insurance and any attached addendum prepared, issued, or requested in violation of this Section shall be null and void and of no force and effect.

N. Any person who willfully violates this Section may be fined not more than one thousand dollars per violation.

O. The commissioner of insurance shall have the power to examine and investigate any complaint or allegation of specific violations by any person who has allegedly engaged in an act or practice prohibited by this Section and to enforce the provisions of this Section. Examinations or complaint investigations conducted by the commissioner under this Subsection shall be subject to the provisions of R.S. 22:1983(J).

P. Pursuant to the Administrative Procedure Act, the commissioner of insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the purposes of this Section.

Redesignated from R.S. 22:881.1 by Acts 2010, No. 375, § 2, eff. Jan. 1, 2011. Added by Acts 2009, No. 335, § 1. Amended by Acts 2010, No. 1017, § 1, eff. Aug. 15, 2010; Acts 2010, No. 1017, § 1, eff. Jan. 1, 2011.

Effective Dates—Acts 2010, No. 1017

Sections 2 and 3 of Acts 2010, No. 1017 (§ 1 of which amended R.S. 22:881.1 [now this section]) provide:

"Section 2. The provisions of this Act amending Subsections A and C of this Section and the provisions of this Act enacting Subsections D and E of this Section shall become effective on August 15, 2010.

"Section 3. Except as otherwise provided in Section 2 of this Act, the provisions of this Act shall become effective on January 1, 2011."

PART II. LIFE INSURANCE AND ANNUITIES

SUBPART A. LIFE INSURANCE AND ANNUITIES IN GENERAL

§ 901. 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; however, 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 under the contract 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 receiving them.

C. "Insurable interest" as used in this Section and in R.S. 22:856 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.

(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) A person 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 under the contract accruing upon the death, disablement, or injury of the individual insured when the beneficiary, assignee, or other payee is either:

(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.

(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. Nothing contained in this Section 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. Nothing contained in this Section 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.

Renumbered from R.S. 22:613 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 246, § 1; Acts 1987, No. 743, § 1; Acts 1995, No. 1244, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 902. 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 named 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 named beneficiaries or owners shall have been designated beneficiaries in the policies, the 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.

Renumbered from R.S. 22:614.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 776, § 1. Amended by Acts 1992, No. 1130, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 903. 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.

Renumbered from R.S. 22:180 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 904. 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 was made, if 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 producer 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 stated in this Section. 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.

Renumbered from R.S. 22:171 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 905. Written notice required before lapsing life policies

A. 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 nonpayment 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 shall have been duly addressed and mailed to the owner of the policy and 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 and 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. Such notice shall state both of the following:

(1) The amount of such premium, installment, loan, or interest, or portion thereof due on such policy.

(2) The place where it shall be paid and the person to whom the same is payable.

B. No policy shall be forfeited or declared forfeited or lapsed until the expiration of thirty days after the mailing of such notice. Any payment demanded by the notice and made within the time limit shall be fully compliant with the requirements of the policy in respect to the time of the payment.

C. The affidavit of any officer, clerk, or representative 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.

D. This Section shall not apply to group life insurance policies.

Renumbered from R.S. 22:177 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 1016, § 2; Acts 2011, No. 19, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 906. Mortality endowments prohibited

A. No life insurer, including industrial, service, nonprofit 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 Subsection B of this Section.

B. Any life insurer specified in Subsection A of this Section operating on the plan specified in Subsection A of this Section in this state since before October 1, 1948, may continue to operate 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 28, 1936.

Renumbered from R.S. 22:178 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 907. 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 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.

Renumbered from R.S. 22:179 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 908. 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.

Renumbered from R.S. 22:182 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1103, § 1.

§ 909. Life insurance; prepayment of certain benefits

Rules and regulations concerning accelerated benefits relating to life insurance as provided in R.S. 22:47(1) shall be promulgated by the commissioner.

Renumbered from R.S. 22:644 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 909, § 1. Amended by Acts 1999, No. 1312, § 1, eff. July 12, 1999.

§ 910. Life insurance and annuities; replacement

Rules and regulations concerning replacement of life insurance and annuities as provided in R.S. 22:47(1) and (17) shall be promulgated by the commissioner.

Renumbered from R.S. 22:644.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1312, § 1, eff. July 12, 1999. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 911. 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.

Renumbered from R.S. 22:645 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 912. 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, 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 person, and such proceeds and avails shall also be exempt from all liability for any debt of the 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 Paragraph (1) of this Subsection 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 request of a creditor. An insurer shall be entitled to be paid by preference and priority over the claim of any seizing creditor the balance of any bona fide loan to the insured or owner which is secured by such interest or value in the policy or contract.

B. (1) The lawful beneficiary, assignee, or payee, including the annuitant's estate, of an annuity contract 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 person, saving the rights of forced heirs, and the proceeds and avails shall also be exempt from all liability for any debt of the 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 savings 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 savings account established pursuant to R.S. 17:3095 shall be entitled to the proceeds and avails of the education savings 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 person, except the rights of forced heirs, and the proceeds and avails shall also be exempt from all liability for any debt of the 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 savings account depositor's agreement.

(b) Whether or not the policy, contract, or education savings 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 savings account owner if the beneficiary, assignee, or payee shall predecease the 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 savings account owner.

E. No person shall be compelled to exercise any rights, powers, options, or privileges under any policy, contract, or education savings 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 the policy that may have been assigned, and any advance payments made on or against the policy.

Renumbered from R.S. 22:647 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by 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. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2012, No. 271, § 1.

§ 913. 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 the 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 the renunciation had not taken place.

Renumbered from R.S. 22:648 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 914. Requirements of variable life and variable annuities

Except for R.S. 22:951(A)(1), (6), and (7) in the case of a variable annuity contract and R.S. 22:931(A)(1), (7), and (9), R.S. 22:933, 934, 935, and 936 in the case of an individual variable life insurance contract, and R.S. 22:942(3) in the case of a group variable life insurance contract and except as otherwise provided in Subpart C of Part IV of Chapter 2 of this Title, 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 the contract; any group variable life insurance contract shall contain a grace provision appropriate to the contract and any such variable annuity contract shall contain grace, reinstatement, and nonforfeiture provisions appropriate to that contract.

Renumbered from R.S. 22:1500(K) by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 915. 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.

Renumbered from R.S. 22:1521 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1968, No. 157, §§ 1, 2; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 916. Inapplicability to reinsurance

R.S. 22:931, 942, and 951 shall not apply to contracts of reinsurance.

Renumbered from R.S. 22:181 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 917. Life insurance policy or annuity issued to fund a pre-need funeral contract

A. A funeral establishment or any entity involved in the marketing, preparation, or funding of a pre-need funeral contract shall not be designated as the owner of a life insurance policy or annuity issued to fund that pre-need funeral contract. If a funeral establishment is designated as the primary beneficiary, the payment of the proceeds of the insurance policy or annuity to the funeral establishment shall be conditioned on the funeral establishment's delivery of the funeral services or merchandise. If the funeral establishment named as primary beneficiary does not provide the funeral services or merchandise for the insured, the contingent beneficiary named in the life insurance policy or annuity shall receive the proceeds of the life insurance policy or annuity.

B. If a life insurance policy or annuity has been issued or assigned for the purpose of funding a pre-need funeral contract, the insurer shall not pay the benefits of the insurance policy, including the cash surrender value, to a funeral establishment, unless the insurer, as a condition to paying the benefits of the insurance policy, receives from the funeral establishment a certified copy of the death certificate of the insured.

Redesignated from R.S. 22:937 by Acts 2011, No. 94, § 3, eff. Jan. 1, 2012. Added by Acts 2008, No. 205, § 1, eff. Jan. 1, 2009.

SUBPART B. INDIVIDUAL LIFE

§ 931. Life insurance policies; standard provisions

A. No policy of life insurance, except as stated in Subsection C of this Section, 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) **Grace period.** 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 the 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 percent per annum, on any overdue premium, may be deducted from any amount payable under the policy in settlement.

(2) **Incontestability.** 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 nonpayment 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) **Entire contract.** 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) **Misstatement of age.** 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) **Participating policy.** If the policy is a participating policy, a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy.

(6) **Nonforfeiture options.** A provision in accordance with R.S. 22:934 through 936 specifying the options, if any, available under the policy in the event of default in a premium payment; however, the mortality table and rate of interest used as a basis for the calculation of the options shall be designated by the policy.

(7) **Policy loan.** 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 Subpart, 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 percent per annum on policy contracts in effect prior to September 10, 1982, or in accordance with the provisions of R.S. 22:932 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 the 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. 22:905, 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) **Nonforfeiture benefits.** A provision specifying the basis used in determining nonforfeiture 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) **Reinstatement.** 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 such policy with the interest at a rate not exceeding six percent per annum compounded annually.

(10)(a) **Free look period.** 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 the 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 required in this Subparagraph or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the policyholder. This Subparagraph shall not apply to travel insurance policies which by their terms are not renewable.

(b) If the policy is delivered by a producer, 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 producer 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 producer for two years.

(11) **Lump sum payment.** A provision which allows election by the beneficiary of an option to receive benefits in the form of a lump sum payment. This Paragraph shall not apply to policies of industrial life insurance or service insurance.

(12) **Conversion notice.** (a) A provision requiring that the insurer notify the policyholder of his option to convert his policy from term life insurance to permanent life insurance at least thirty-one days prior to the expiration of the conversion option, if such an option is applicable. Such notice shall be a separate notice or contained in either a premium notice or an annual premium

summary.

(b) Evidence of a business procedure or practice to provide the required notice by mailing the notice to the policyholder at the address shown in the policy shall be sufficient to prove that the required notice was provided.

(c) This Paragraph shall not apply to a policyholder who is covered under a child term rider.

B. Exclusions and restrictions. 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:

(1) 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 either in:

(i) The military, naval, or air forces of any country at war, declared or undeclared.

(ii) 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.

(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 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.

(2) In the event of death as to which there is an exclusion or restriction pursuant to Subparagraph (1)(a), (c), (d), or (e) 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.

(3) In the event of death as to which there is an exclusion or restriction pursuant to Subparagraph (1)(b) of this Subsection, the insurer shall pay the greater of:

(i) The amount specified in Paragraph (2) of this Subsection.

(ii) 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.

(4) 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.

(5) Nothing contained in this Subsection 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 provisions or portions thereof of this Section not applicable to single premium or nonparticipating 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.

Renumbered from R.S. 22:170 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2012, No. 271, § 1; Acts 2014, No. 47, § 1.

§ 932. 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:

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

(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 or 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 otherwise provided in this Subsection. The insurer shall send reasonable advance notice of any increase in the rate to policyholders with loans, and include in the notices required in this Subsection, 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. 22:936 or 952, 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.

Renumbered from R.S. 22:170.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1982, No. 465, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 933. Automatic premium loans

Nothing in R.S. 22:935 or 936 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.

Renumbered from R.S. 22:169 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 934. Policies to contain nonforfeiture benefits

Every life or endowment insurance policy, other than a term life policy for twenty years or less and an industrial life insurance policy with coverage of one thousand two hundred fifty dollars or less issued pursuant to R.S. 22:146, issued on the life of a resident of this state or delivered within this state by any insurer, on or after January 1, 1937, unless the company exercises its option provided in R.S. 22:936(H), shall require that after three full annual premiums have been paid, the policy shall not be forfeited without value for the nonpayment of any subsequent premiums or for policy loan indebtedness or the interest thereon except as provided in R.S. 22:935.

Renumbered from R.S. 22:166 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 90, § 1, eff. Jan. 1, 1959 at 12:00 Noon. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

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

Every life or endowment insurance policy, other than a term life policy for twenty years or less and an industrial life insurance policy with coverage of one thousand two hundred fifty dollars or less, pursuant to the provisions of R.S. 22:146, issued on or after January 1, 1907, by a legal reserve life insurance company, after being in force for three full years, shall not be forfeited without value for the nonpayment of any subsequent premiums or for policy loan indebtedness or the interest thereon, unless the company exercises its option provided in R.S. 22:936(H). The nonforfeiture value per hundred dollars of coverage under the policy is determined as the sum of the legal reserve and accumulated dividends, less any policy loan indebtedness and a surrender charge equal to the greater of one-fifth of the legal reserve or two dollars and fifty cents. Unless the policy owner elects one of the other nonforfeiture options within the policy, the nonforfeiture value as determined in this Section shall be applied towards the policy's automatic nonforfeiture option. The automatic nonforfeiture option shall be the purchase of paid up life or endowment insurance on the same life at the age at the time of forfeiture and under the same terms, except as to the payment of premiums, as the original policy, or to continue the insurance in force at its full amount, including the amount of accumulated dividends, less any existing policy loan indebtedness; however, such surrender value will purchase nonparticipating temporary insurance at net single premium rates using the standard as prescribed by the insurer, at the age at the time of forfeiture, provided that in the case of an endowment policy, if the sum needed to purchase temporary insurance is more than that needed to continue the insurance to the end of the policy's endowment term, the excess shall be used to purchase

pure endowment insurance payable at the end of the policy's endowment term using the purchase rates as prescribed by the insurer. When determining the net single premium rates for temporary insurance, the insurer may use one hundred thirty percent of the reserve mortality assumption as the mortality rate. This further provision shall not apply to any mortality table constructed on the basis of insurance company experience prior to 1900. Any attempted waiver of the provisions of this Section in any application, policy, or otherwise shall be void, and any value allowed in lieu thereof shall be at least equal to the net value of the temporary or pure endowment insurance as provided in this Section. The term of temporary insurance provided in this Section shall include the period of grace, if any.

Renumbered from R.S. 22:167 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 91, § 1, eff. Jan. 1, 1959 at 12:00 Noon. Amended by Acts 1974, No. 4, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 936. 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 of this Section, no policy of life insurance, except as stated in Subsection K of this Section 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 in 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 provisions of Paragraph (1) of this Subsection not applicable because of the structure 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 this 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 R.S. 9:3500 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 of this Section, 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) However, 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 Paragraph (1) 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) However, 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 of seventy-one years, the cash surrender value referred to in Paragraph (1) 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 of this Section, 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)(a) This Subsection shall not apply to policies issued on or after the effective date of Subsection G of this Section as defined therein. Except as provided in Paragraph (3) 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 all of the following:

(i) The then present value of the future guaranteed benefits provided for by the policy.

(ii) 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.

(iii) Forty percent of the adjusted premium for the first policy year.

(iv) 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.

(b) In applying the percentages specified in Items (a)(iii) and (iv) of this Paragraph, 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; however, 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, F, and G of this Section, 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. 22:141, 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; however, 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 thirty percent of the rates of mortality according to such applicable table; however, 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 of this Section 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 of this Section, 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. However, 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; however, 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. However, 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) After July 27, 1960, 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 of this Section as defined therein. In the case of industrial policies issued on or after the effective date of this Subsection as defined herein and in Subsection L of this Section, 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; however, 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)(a) 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:

(i) The then present value of the future guaranteed benefits provided for by the policy.

(ii) 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.

(iii) One hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined.

(b) However, in applying the percentage specified in Item (a)(iii) of this Paragraph, 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; however,

(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 of this Section 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 life 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 life insurance.

(e) For life 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) For policies issued prior to the operative date of the valuation manual, any ordinary life 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) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioner's standard mortality table for use in determining the minimum nonforfeiture standard that 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. If the commissioner approves by regulation any commissioner's standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard shall supersede the minimum nonforfeiture standard provided by the valuation manual.

(h) For policies issued prior to the operative date of the valuation manual, any industrial life 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.

(i) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioner's standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioner's 1961 Standard Industrial Mortality Table or the Commissioner's 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any commissioner's standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after operative date of the valuation manual, then that minimum nonforfeiture standard shall supersede the minimum nonforfeiture standard provided by the

valuation manual.

(9)(a) For policies issued prior to the operative date of the valuation manual, 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. 22:753, rounded to the nearer one quarter of one percent.

(b) For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(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 of this Section, 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 of this Section. 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 through G of this Section 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 of this Section, 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.

(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) All 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; however, 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 of this Section, whichever is applicable, shall be the same as are the effects specified in such Subsection B or Subsection D of this Section, whichever is applicable on the cash surrender values defined in that Subsection.

(3)(a) 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 of this Section, whichever is applicable. Except as is required by Subparagraph (b) 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.

(b) No percentage after the later of the two policy anniversaries specified in Subparagraph (a) of this Paragraph shall apply to fewer than five consecutive policy years; however, no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in Subsection D or G of this Section, 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 of this Section. 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 Subparagraphs (I)(1)(a) through (f) of this Section 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.

(7) The operative date of the valuation manual as used in this Section shall be the date determined according to R.S. 22:753(C)(2).

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 of this Section, 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 through G of this Section, 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 a producer 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 Subpart D or E of Part I of Chapter 2 of this Title, 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. 22:935.

Renumbered from R.S. 22:168 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 92, § 1, eff. Jan. 1, 1959 at 12:00 Noon. Amended by 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; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2013, No. 349, § 1, eff. Jan. 1, 2014.

§ 937. Redesignated as R.S. 22:917 by Acts 2011, No. 94, § 3, eff. Jan. 1, 2012

SUBPART C. GROUP LIFE

§ 941. 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, or a 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 were purchased by the employer directly from the insurer. 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 other than Louisiana, 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.

(5) Repealed by Acts 2011, No. 406, § 4, eff. July 5, 2011.

B. Each policy of group life insurance may cover one or more employees or members at date of issue as follows:

(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 at the end of the first year or of any subsequent year of insurance 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 be extended to insure 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 intellectual or physical disability, who became so incapable prior to attainment of age twenty-one, and any other person dependent upon the insured employee or member in accordance with the plan which precludes individual selection by the employees or members or by the employer or trustee.

Renumbered from R.S. 22:175 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 99, § 1. Amended by 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; Acts 2007, No. 260, § 1, eff. July 6, 2007; Acts 2008, No. 404, § 1, eff. June 21, 2008; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2014, No. 811, § 11, eff. June 23, 2014.

Legislative Intent; Preferred Terminology; Authority to Change Terminology—Acts 2014, No. 811

Sections 35 to 37 of Acts 2014, No. 811, provide:

"Section 35. (A) The legislature hereby finds that language used to refer to

persons with disabilities and other persons with exceptionalities shapes and reflects attitudes toward and perceptions of such persons by society.

"(B) It is hereby declared that the intent of the legislature is to delete from the lawbodies of this state terms that convey negative or derogatory perceptions of persons with disabilities and other persons with exceptionalities. Accordingly, the intent of the legislature is to provide in this Act for establishment of new terminology in law that is more appropriate than the terminology replaced herein, and which conveys no explicit or implicit dehumanization of persons with disabilities or other persons with exceptionalities.

"(C) It is not the intent of the legislature that changes in terms referring to persons with disabilities and other persons with exceptionalities, as effected by this Act, alter or affect in any way the substance, interpretation, or application of any existing law or administrative rule.

"(D) Nothing in this Act shall be construed to expand or diminish any right of or benefit for any person provided by any existing law or administrative rule.

"Section 36. (A)(1) For the purposes of the provisions of law amended by this Act, references to 'intellectual disability' shall mean any condition formerly referred to as 'mental retardation'.

"(2) For the purposes of the provisions of law amended by this Act, references to a 'person with an intellectual disability' shall mean a person formerly referred to as 'mentally retarded'.

"(3) For the purposes of the provisions of law amended by this Act, the term 'disability', as used to describe a condition or characteristic of a person, shall have the meaning of the former term 'handicap' as used in the same manner.

"(4) For the purposes of the provisions of law amended by this Act, references to a 'person with a physical disability' and a 'person with a disability' shall mean a person formerly referred to as 'physically handicapped', a 'handicapped person', 'the handicapped', a 'crippled person', a 'disabled person', or 'the disabled'.

"(5) For the purposes of the provisions of law amended by this Act, references to a 'person who is infirm' and a 'person with an infirmity' shall have the meaning of the former terms 'the infirm' and 'the infirmed'.

"(6) For the purposes of the provisions of law amended by this Act, references to a person who 'acquires a disability' shall have the meaning of the former references to a person who 'becomes disabled'.

"(7) For the purposes of the provisions of law amended by this Act, references to 'certified as having a disability' shall have the meaning of the former references to 'certified as disabled'.

"(8) For the purposes of the provisions of law amended by this Act, the terms 'accessible' and 'accessibility' have the meanings, respectively, of the former terms 'handicapped accessible' and 'handicapped accessibility'.

"(9) For the purposes of the provisions of law amended by this Act, references to a 'person with a mobility impairment' shall mean a person formerly referred to as 'mobility-impaired'.

"(10) For the purposes of the provisions of law amended by this Act, references to a 'person with mental illness' shall mean a person formerly referred to as either 'the mentally ill' or 'mentally ill person'.

"(11) For the purposes of the provisions of law amended by this Act, the linguistic paradigm known as 'person first language', which emphasizes a person's humanity over any condition or characteristic the person may have, is employed wherever possible to refer to persons with disabilities and other persons with exceptionalities. The legislature hereby recognizes and affirms the importance of person first language as a respectful and preferred way of referring to persons with disabilities and other persons with exceptionalities.

"(B) Each agency, board, commission, department, office, and other instrumentality of the state to which the legislature has delegated authority to promulgate rules and regulations in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., is hereby authorized and requested to employ the preferred terminology described in Section 36(A) of this Act in referring to persons with disabilities and other persons with exceptionalities in duly promulgated administrative rules, policy publications, and materials published in paper format or electronically, whether for internal use or public use, including but not limited to informational brochures, resource guides, reference materials, manuals, and the content of any Internet website or other electronic media. The provisions of this Section shall apply prospectively; however, nothing herein shall be construed to limit any agency, board, commission, department, office, or other instrumentality of the state from amending existing administrative rules for the purpose of instituting the preferred terminology described in Section 36(A) of this Act.

"(C) The legislative services offices of the House of Representatives and the Senate are hereby authorized and requested to publish guidance in legislative drafting manuals and in other professional resources as those offices may deem appropriate concerning use of the preferred terminology described in Section 36(A) of this Act.

"Section 37. The Louisiana State Law Institute is hereby authorized and requested to change terminology referring to persons with disabilities and other persons with exceptionalities throughout the revised statutes and codes of this state wherever necessary to institute the preferred terminology described in Section 36(A) of this Act."

§ 942. Standard provisions for group life policies

Each policy of group life insurance as defined in R.S. 22:941 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 R.S. 22:941(A)(3), except that, where policies are issued pursuant to that 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 provided 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 R.S. 22:941(B)(4), 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 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 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 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) Nonforfeiture provision. 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.

Renumbered from R.S. 22:176 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2014, No. 47, § 1.

§ 943. 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) of this Section.

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) of this Section 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) of this Section 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 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. 22:942(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.

Renumbered from R.S. 22:176.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 128, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 944. Exemption of proceeds; group life

A. A policy of group life insurance or the proceeds payable to the individual insured or to the beneficiary, 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, 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. 22:941(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.

Renumbered from R.S. 22:649 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 945. 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.

Renumbered from R.S. 22:652.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 558, § 1, eff. Jan. 1, 1985. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003.

SUBPART D. INDIVIDUAL ANNUITIES

§ 951. 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) Grace period: 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 percent per annum, on any overdue payments, may be deducted from any amount payable under the contract in settlement.

(2) Incontestability: 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) Entire contract: 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) Misstatement of age or sex: 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 percent per annum, shall be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

(5) Participating policy: If the policy is a participating policy, a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

(6) Nonforfeiture options: 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) Reinstatement: 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 percent 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) Free look period: 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 a producer, 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 or its producer 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 Subparagraph shall be retained by the producer for two 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 Subsection A of this Section, except that under Paragraph (1) of Subsection A of this Section 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.

Renumbered from R.S. 22:173 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1990, No. 580, § 1; Acts 1990, No. 715, § 1, eff. July 20, 1990; Acts 1993, No. 141, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 952. 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 a producer or other representative of the company issuing the contract.

(3) For purposes of this Section and R.S. 22:951(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 of this Section, no contract of annuity, except as stated in Subsection A of this Section, 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 of this Section.

(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 of this Section.

(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 R.S. 9:3500 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) 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.

(b) 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 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 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.

Renumbered from R.S. 22:173.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1979, No. 370, § 4. Amended by Acts 1990, No. 715, § 1, eff. July 20, 1990; Acts 1991, No. 951, § 1; Acts 2002, 1st Ex.Sess., No. 129, § 1; Acts 2003, No. 386, § 1; Acts 2004, No. 497, § 1, eff. June 25, 2004; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

SUBPART E. GROUP ANNUITIES

§ 961. Group annuity contracts; definition; standard provisions

A. 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.

B. 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) Grace period: 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 percent per annum for the number of days of grace elapsing before such payment.

(2) Entire contract: 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) Misstatement of age or sex: 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) Ascertainment of the benefit: 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) Certificates: 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.

Renumbered from R.S. 22:174 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§§ 962 to 970. Reserved for future legislation

PART III. HEALTH AND ACCIDENT COVERAGE

SUBPART A. HEALTH AND ACCIDENT INSURANCE; STANDARDS AND CONTRACT REQUIREMENTS IN GENERAL

§ 971. 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 priority 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 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 harm patients. Because many states have passed patient protection laws that are appropriate to their states, 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.

Renumbered from R.S. 22:10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 68, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 971.1. Regulation of health insurers

A. 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.

B. (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.

Added by Acts 2009, No. 503, § 1.

§ 972. Approval and disapproval of forms; filing of rates

A. No policy or subscriber agreement of a health insurance issuer, hereafter including a health maintenance organization, 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, which may include a certificate, be used in connection therewith until a copy of the form and of the rates and of the classifications of risks pertaining thereto have been filed with the department. No policy, subscriber agreement, endorsement, rider, or application, hereinafter referred to as a policy or subscriber agreement, shall be used until the expiration of sixty days after the form has been filed unless the department gives its written approval prior thereto. Written notification shall be provided to the health insurance issuer specifying the reasons a policy form or subscriber agreement does not comply with the provisions of this Subpart. It shall be unlawful for any health insurance issuer to issue any form in this state not previously submitted to and approved by the department. An aggrieved party affected by the department's decision, act, or order in reference to a policy form or subscriber agreement may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

B. After providing twenty days' notice to the health insurance issuer, the department may withdraw its approval of any such policy form or subscriber agreement on any of the grounds stated in R.S. 22:862. It shall be unlawful for the health insurance issuer to issue such policy form or subscriber agreement or use it in connection with any policy or subscriber agreement after the effective date of such withdrawal of approval. An aggrieved party affected by the department's decision, act, or order in reference to a policy form or subscriber agreement may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

C. The department shall not disapprove or withdraw approval of any such policy form or subscriber agreement on the ground that its provisions do not comply with R.S. 22:975 or on the ground that it is not printed in uniform type if it shall be shown that the rights of the insured, the beneficiary, or the subscriber under the policy or subscriber agreement as a whole are not less favorable than the rights provided by R.S. 22:975 and that the provisions or type size used in the policy or subscriber agreement are required in the state, district, or territory of the United States in which the health insurance issuer is organized, anything in this Subpart to the contrary notwithstanding.

D. Policy forms and premium rates for major medical health and accident and dental policies, including but not limited to policies subject to the requirements of Title I of Public Law 111-148, shall be exempt from disclosure under R.S. 44:1 et seq., the Public Records Law, until the commencement of the open enrollment period of the policy year during which the forms and rates are to be utilized. A health insurance issuer, including a health maintenance organization, shall mark such filings as confidential or proprietary in order to utilize the exemption authorized in this Subsection. The exemption authorized in this Subsection shall not prevent the commissioner from publishing a summary or description of rate filings in the operation of an effective rate review program pursuant to Section 2794 of the Public Health Service Act.

E. All references to rates in this Section shall be controlled by Subpart D of this Part, R.S. 22:1091 through 1099.

Renumbered from R.S. 22:211 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 317, § 1; Acts 2010, No. 188, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2014, No. 695, § 1, eff. June 18, 2014; Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 973. Form of policy

No health and accident policy or contract shall be delivered or issued for delivery on risks in this state unless all of the following conditions are met:

(1) The entire money and other consideration therefor are expressed in the policy or contract.

(2) The time at which the insurance takes effect and terminates is expressed in the policy or contract.

(3) It purports to insure only one person except as specifically provided in this Subpart .

(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 .

(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".

(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 of the form.

(7)(a) There is prominently printed on or attached, a notice to the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions. 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. Any premium advanced by the insured, upon such surrender, shall be immediately

returned to him; however, the insurer shall have the option of printing or attaching the notice required by this Subparagraph 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 travel insurance policies which by their terms are not renewable.

(b) If the policy is delivered by a producer, 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, or its producer 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 producer for three years. In addition, the insurer or producer may utilize commercial carriers or other commercially recognized carriers to deliver the policy to the policyholder; however, the insurer or producer 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 to electronic delivery, and documentation of 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 the policy a statement informing the policyholder of such option.

Renumbered from R.S. 22:212 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 170, § 1; Acts 1993, No. 141, § 1; Acts 2003, No. 858, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 974. Standard forms

The commissioner of insurance may, in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., promulgate 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 R.S. 22:972, 973, 975-983, 985-990, 992, 993, 999-1014, 1021-1048, 1091-1096, 1111, and 1156, for the purpose of expediting his approval of such contracts pursuant to this Code. No promulgation shall be inconsistent with standard provisions as required pursuant to R.S. 22:863.

Renumbered from R.S. 22:622 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 317, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 975. Health and accident policy provisions

A. Required provisions. Each 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. 22:972(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 producer 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 on or attached to the policy.

(2) Reinstatement: If default is made in the payment of any agreed premium for this policy, the subsequent acceptance of the defaulted premium by the insurer or by any producer authorized by the insurer to accept such premium, shall reinstate the policy; however, 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 an 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 must be given to the insurer. Such notice given by or on behalf of the insured or the beneficiary to the insurer at 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 notice within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give 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 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 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) Proof of loss: Affirmative written proof of loss must be furnished to the insurer at its 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 proof is furnished as soon as reasonably possible and in no event later than one year from the time proof is otherwise required. Any 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: Indemnity claims 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 indemnity claims 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 indemnity claims 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 indemnity claims 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 which they may be equitably entitled, 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 which they may be equitably entitled. 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; however, 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 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 required for the surrender or assignment of this policy, nor for change of beneficiary, nor for any other changes in this policy.

(11) Legal action: No legal action shall be brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy. No legal action shall be brought after the expiration of one year after the time proof of loss is 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 extended to agree with the minimum period permitted by such law.

(13) Time limit on certain defenses:

(a)(i) 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. This 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 Paragraphs (B)(1), (2), (3), and (4) of this Section in the event of misstatement with respect to age or occupation or other insurance.

(ii) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium either until at least age fifty, or, in the case of a policy issued after age forty-four, 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. 22:1824.

B. Other optional provisions. No such policy shall be delivered or issued for delivery containing provisions respecting the matters set forth in this Subsection 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 suffers injury or sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while performing services for compensation in any trade, business, or occupation so classified, the insurer will pay only such portion of the indemnity 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 trade, business, or occupation. In applying this Paragraph, 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; however, 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 determined as based on 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, because of the loss occurring after such age, shall be limited to a return of the premiums paid thereafter.

(3) Other insurance with this insurer: An insurer may do either of the following:

(a) If a like policy or policies previously issued by this insurer to the insured are in force concurrently with this policy, 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.

(b) 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 carries 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 indemnity otherwise provided hereunder as the indemnity of which the insurer had notice, including the indemnity under this policy , bear to the total amount of like indemnity 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 indemnity thus determined.

(5) Relation of earnings to insurance: If the total monthly amount of loss of time indemnity 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 indemnity specified in the policy as the amount of such monthly earnings of the insured bears to the total amount of monthly indemnity 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 indemnity actually paid hereunder; but this shall not operate to reduce the total monthly amount of indemnity payable under all such policies or certificates upon the insured below the sum of one hundred dollars or the sum of the monthly indemnity 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 from such payment.

(7) Cancellation: The insurer may cancel this policy at any time subject to the provisions of R.S. 22:1012. 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. 22:887(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 terms specified in this Paragraph. 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.

Renumbered from R.S. 22:213 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125; Acts 1958, No. 97, § 1. Amended by 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 1991, No. 777, § 1, eff. Sept. 30, 1991; Acts 1993, No. 57, § 1; Acts 1993, No. 653, § 1; Acts 2010, No. 919, § 1, eff. Jan.

1, 2011.

§ 976. Repealed by Acts 2013, No. 325, § 2, eff. Dec. 31, 2014

§ 977. Cancellation by insurer and grace period; individual health and accident policies

A. Every insurer, including a trust subject to the provisions of R.S. 22:401 et seq., issuing a policy of individual, group, family group, blanket, or association health and accident insurance shall include in such policy a provision providing the policyholder a grace period of thirty days from the date the premium was due. If the premium is paid during the grace period, then coverage shall remain in effect pursuant to the provisions of the policy.

B. Whenever an insurer issues an individual accident and health policy and 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 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.

Renumbered from R.S. 22:213.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 886, § 1. Amended by Acts 2006, No. 396, § 1, eff. Jan. 1, 2007; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 978. 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. 22:887(A) through (D), every insurer, including any trust subject to the provisions of R.S. 22:401 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 Subpart 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. 22:887(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 that 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 Subpart that 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 of premiums.

D. At least ninety days prior to the date on which a group policy is to be renewed or terminated, every health insurance issuer providing coverage to an employer group comprising more than one hundred enrolled employees shall provide the employer group with information as to the premium rate or amount to be paid to renew the group policy for the next policy year. No later than eighty days prior to the date of renewal or termination, the employer group may make written request, by certified mail, to the group insurance issuer for the currently available utilization data and aggregate paid claims and premium data accumulated for the period of the current policy year. The health insurance issuer shall provide this data to the employer group within fourteen business days of receipt of the request.

E. (1) Every health and accident insurance issuer, including a health maintenance organization, shall, upon request, release to each group policyholder and agent of a policyholder claims data and shall provide this data within no more than fourteen business days of receipt of the request, which shall include the following items:

(a) The net claims paid by month during the current and the two immediately preceding policy periods.

(b) The monthly enrollment by employee only, employee and spouse, and employee and family during the current and the two immediately preceding policy periods.

(c) The amount of any claims reserve established by the insurance provider against future claims under the policy.

(d) Claims over ten thousand dollars including claim identifier, the date of occurrence, the amount of claims paid and those unpaid or outstanding, and claimant health condition or diagnosis during the current and the two immediately preceding policy periods. The data shall provide a unique identifying number or code for the claimant.

(e) A complete listing of all potential catastrophic diagnoses and prognoses involving persons covered under the policy provisions. The data shall provide a unique identifying number or code for the claimant.

(2) A health and accident insurer that discloses data or information in compliance with the provisions of this Section may condition any such disclosure upon the execution of an agreement for immunity from civil liability.

(3) A health and accident insurer that provides data or information in compliance with the provisions of this Section shall be immune from civil liability for any acts or omissions of any person's subsequent use of such data or information.

(4) The provisions of this Subsection shall not be construed to authorize the disclosure of the identity of a particular employee covered under the group policy, nor the disclosure of any individual employee's particular health insurance claim, condition, diagnosis, or prognosis, which would violate federal

or state law.

(5) For purposes of this Subsection, "claim identifier" shall be defined as data that reflects a number designation including but not limited to an alphabetic or alphanumeric designation which shall not be a name identifier of an employee, employee's spouse, or employee's dependent.

(6) The provisions of this Subsection shall not apply to limited benefit insurance, as defined by R.S. 22:47(2)(c).

(7) A plan sponsor and the plan sponsor's agent are entitled to receive protected health information under this Section only after an appropriately authorized representative of the plan sponsor or agent makes to the health and accident insurer a certification substantially similar to the following certification:

'I hereby certify and have demonstrated that the plan documents comply with the requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor or agent may receive from the group health plan to perform the plan administration functions.'

(8) A plan sponsor or agent that does not provide the certification required in Paragraph (7) of this Subsection is not entitled to receive the protected health information described in Subparagraphs (1)(d) and (e) of this Subsection, but is entitled to receive a report of claim information that includes the other information required by this Subsection.

F. For purposes of this Section, the term "health and accident insurer" or "health and accident insurance issuer" shall include a health maintenance organization, the term "policy" shall include a subscriber agreement, and the term "policyholder" shall include an enrollee or subscriber of a health maintenance organization.

G. Nothing in this Section shall be construed to require an insurer to provide information protected as confidential by the Health Insurance Portability and Accountability Act of 1996 or any other provision of federal law.

Renumbered from R.S. 22:215.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 538, § 1. Amended by Acts 1991, No. 933, § 1; Acts 1993, No. 57, § 1; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2010, No. 997, § 1; Acts 2012, No. 217, § 1, eff. Jan. 1, 2013; Acts 2014, No. 558, § 1.

§ 979. 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 except that no health insurance issuer or health maintenance organization issuing group or individual policies or subscriber agreements shall increase its premium rates or reduce covered benefits under any policy or subscriber agreement after the commencement of the minimum one-hundred-eighty-day period provided for in R.S. 22:1068(C)(2)(a)(i) or 1074(C)(2)(a)(i).

Renumbered from R.S. 22:229.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 944, § 1. Amended by Acts 1997, No. 1471, § 1; Acts 2010, No. 595, § 1.

§ 980. 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 limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:213.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 310, § 1. Amended by Acts 1995, No. 593, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 981. Repealed by Acts 2013, No. 325, § 2, eff. Dec. 31, 2014

§ 982. 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,[1] 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.

Renumbered from R.S. 22:214.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 388, § 1. Amended by Acts 1997, No. 1138, § 1, eff. July 14, 1997; Acts 2003, No. 1149, § 1.

[1] See, inter alia, 42 U.S.C.A. 300gg et seq.

§ 983. Application

A. The falsity of any statement in the application for any policy covered by this Subpart shall not bar the right to recovery under the policy 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.

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 a manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Renumbered from R.S. 22:219 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 984. 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 policyholder 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 insurer.

C. The commissioner may promulgate rules and regulations implementing the provisions of this Section.

Renumbered from R.S. 22:250.18 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 32, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 985. Notice; waiver

The acknowledgement by any insurer of the receipt of notice given under any policy covered by this Subpart or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Renumbered from R.S. 22:220 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 986. Nonapplication to certain policies

A. Nothing in this Subpart shall apply to or affect:

(1) Any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage.

(2) Any policy or contract of reinsurance.

(3) Life insurance, endowment or annuity contracts, or supplemental contracts 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. 22:973, 975, 976, 980, 1021, 1022, 1023, and 1156 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 related expenses, 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.

Renumbered from R.S. 22:221 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1976, No. 205, § 1; Acts 1993, No. 652, § 1, eff. Jan. 1, 1994; Acts 2006, No. 396, § 1, eff. Jan. 1, 2007. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 987. Penalties

A. Any insurer, or any officer or agent thereof, issuing or delivering any health and accident policy on risks in this state in willful violation of any provision of this Subpart 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, willfully violating any provision of this Subpart.

Renumbered from R.S. 22:222 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 988. Repealed by Acts 2013, No. 325, § 2, eff. Dec. 31, 2014

§ 989. 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 in which the premium is payable weekly. Every such policy must have printed on it the words "Industrial Policy" and must contain in substance those provisions in R.S. 22:975 as may be applicable. Insurers issuing policies under this Section shall be subject to all the other applicable provisions of this Subpart.

Renumbered from R.S. 22:216 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 990. 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 either:

(1) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation".

(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.

Renumbered from R.S. 22:230 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 879, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 991. 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).

Renumbered from R.S. 22:1535 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1284, § 1.

§ 992. Repealed by Acts 2014, No. 117, § 2

§ 993. Construction of policy issued in violation of this Subpart

A policy issued in violation of this Subpart 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 Subpart, the rights, duties, and obligations of the insurer, the policyholder, and the beneficiary shall be governed by the provisions of this Subpart.

Renumbered from R.S. 22:218 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 994. 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.

Renumbered from R.S. 22:663 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added

by Acts 1972, No. 342, § 1.

§ 995. 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 Section 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.

Renumbered from R.S. 22:668 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1975, No. 265, § 1, eff. Nov. 1, 1975. Amended by Acts 1984, No. 680, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 996. 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.

Renumbered from R.S. 22:662 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1972, No. 754, § 1.

§ 997. Visual services, choice of practitioners

A. Whenever any medical eye care or vision care benefits are provided by or

available through a health maintenance organization, preferred provider organization, managed care organization, accountable care organization, plan or contract of insurance or any medical hospital service contract that are within the lawful scope of practice of a duly licensed optometrist as defined in R.S. 37:1041(C), there shall be no discrimination in the amount of either:

(1) Medical eye care or vision care benefits available to an insured, participant, or other person entitled to such benefits, whether provided by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

(2) Reimbursements or payments to the provider of such medical eye care or vision care services, whether performed by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

B. A duly licensed optometrist shall be entitled to participate in contracts or plans providing for medical eye care or vision care services as a healthcare provider or otherwise, to the same extent as a duly licensed physician, and there shall be no discrimination against any provider, whether an optometrist or physician, who is located within the geographic area of the health maintenance organization, preferred provider organization, managed care organization, accountable care organization, or plan or contract of insurance. A health maintenance organization, preferred provider organization, managed care organization, accountable care organization, plan or contract of insurance, or any medical or hospital service contract shall not impose a co-payment, co-insurance amount, or any other fee on a covered participant or insured that is greater than the amount charged for the same service when provided by an allopathic physician or an osteopathic physician.

C. It shall be unlawful for a health maintenance organization, preferred provider organization, managed care organization, accountable care organization, or plan or contract of insurance to require a duly licensed optometrist to participate as a provider in another medical or vision care plan or contract as a condition of or requirement for participation by such duly licensed optometrist as a provider in any medical or vision care plan or contract.

Renumbered from R.S. 22:664 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1972, No. 60, § 1. Amended by Acts 2012, No. 843, § 1.

§ 998. 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 or by a duly licensed medical psychologist as regulated under the provisions of R.S. 37:1360.51et seq., 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, or a duly licensed medical psychologist is authorized to perform under the provisions of Chapter 15 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.

Renumbered from R.S. 22:665 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1974, No. 481, §§ 1 to 3. Amended by Acts 2009, No. 251, § 5, eff. Jan. 1, 2010.

§ 999. 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 authoritative compendia as identified by the secretary of the United States Department of Health and Human Services.

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 limited benefit health insurance policies or contracts authorized to be issued in the state.

Renumbered from R.S. 22:215.20 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 896, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2009, No. 87, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 999.1. Parity for orally administered anti-cancer medications with intravenously administered or injected anti-cancer medications

A. It is hereby declared that the public policy of this state is that every person within this state with health insurance coverage that provides coverage for cancer treatment shall have access to the type of covered medication used to treat his cancer, as such a decision affects the person's overall, long-term health and quality of life. It is also declared that orally administered anti-cancer medications, although very effective in killing or slowing the growth of cancerous cells, have high out-of-pocket costs to the covered person, impacting the decision of physicians to prescribe such medications, thus restricting patient access to life-saving oral anti-cancer medications. It is further declared that physicians must be able to make the best choice for their patients, considering the unique aspects of each patient and the progress of the disease.

B. (1) A health insurance issuer that provides coverage for cancer treatment shall provide for coverage of prescribed orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

(2) Health insurance coverage of orally administered anti-cancer medications shall not be subject to any prior authorization, dollar limit, copayment, deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected cancer medications, regardless of formulation or benefit category determination by the health insurance issuer.

(3) A health insurance issuer shall not reclassify or increase any type of cost-sharing to the covered person for anti-cancer medications in order to achieve compliance with this Section. Any change in health insurance coverage that otherwise increases an out-of-pocket expense applied to anti-cancer medications shall also be applied to the majority of comparable medical or pharmaceutical benefits covered by the health insurance issuer.

(4) A health insurance issuer that limits the total amount paid by a covered person through all cost-sharing requirements to no more than one hundred dollars per filled prescription for any orally administered anti-cancer medication shall be considered in compliance with this Section. For purposes of this Paragraph, "cost-sharing requirements" shall include copayments, coinsurance, deductibles, and any other amounts paid by the covered person for that prescription.

C. As used in this Section:

(1) "Anti-cancer medications" means medications used to kill or slow the growth of cancer cells.

(2) "Covered person" means a policyholder, subscriber, enrollee, or other individual enrolled in or insured by a health insurance issuer for health insurance coverage.

(3) "Health insurance coverage" or "coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or through a network, and including 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 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 Section, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of this Part, and the Office of Group Benefits.

(5) "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 covered persons to covered health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

D. The provisions of this Section shall not apply to the following:

(1) Limited benefit health insurance policies or contracts.

(2) High deductible health plans or policies that are qualified to be used in conjunction with a health savings account, a medical savings account, or other similar program authorized by 26 U.S.C. 220 et seq.

(3) Qualified health plans offered through a health benefit exchange.

Added by Acts 2012, No. 410, § 1.

Application—Acts 2012, No. 410

Section 2 of Acts 2012, No. 410 provides:

"Section 2. This Act shall be applicable to health insurance coverage that provides coverage for cancer treatment issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after January 1, 2013."

§ 1000. 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 the power to issue policies described in this Section, provided that no policy issued pursuant to this Section shall conflict with other provisions of this Title or with federal law including but not limited to relevant provisions of law governing major medical health and accident policies.

(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, association or a trust for multiple associations who shall be deemed the policyholder, covering one or more employees of such employer or one or more members or employees of members of such association or multiple associations, for the benefit of persons other than the employer, the association or the multiple associations, as well as their officers or trustees, upon some plan which will preclude individual selection.

(ii) The premium may be paid by the employer, association or multiple associations, by the employees, members or employees of 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, association or multiple associations.

(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 Subpart and R.S. 22:984, 1061 through 1079, and 2247 may be issued to an association or trust for multiple associations unless such association or each participating association in the multiple associations, 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, does not condition membership in the association or multiple associations on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee, and does not make health insurance coverage offered through the association or multiple associations available other than in connection with a member of the association or multiple associations. No such policy, issued and considered as group health insurance, as defined under R.S. 22:1061(2)(c), may be issued to an association, trust for an association, or multiple associations unless it or each participating association has been actively in existence for at least five years, has been formed and maintained in good faith for purposes other than obtaining insurance, does not condition membership in the association or multiple associations on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee, and does not make health insurance coverage offered through the association or multiple associations available other than in connection with a member of the association. Such individual or group policy may be issued to a trust established by an association or associations to allow multiple associations to participate.

(v) The insurer shall issue to the employer, association, or the multiple associations 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)(aa) The policy may be issued to an employer, association, a trust for multiple associations, or to the trustees of a fund established by two or more employers in the same industry or by one or more labor unions, by one or more employers, and one or more labor unions or by an association, or multiple associations, or to a multiple employer trust or multiple association trust established by an insurer on behalf of participating employers or participating associations, in the multiple associations, provided all participating employers and employees or members, or employees of members of one of the multiple participating associations have the same statutory protections that would apply if such policy was purchased by the employer, association, or multiple associations directly from the insurer, which trustees shall be deemed the policyholder, to insure with or without any eligible family members including spouse, children until the age of twenty-six, and grandchildren who are in the legal custody of and residing with the grandparent until the age of twenty-six pursuant to R.S. 22:1003 and 1003.1, employees of the employers, members of the association or employees of members of a multiple association, or of the unions for the benefit of persons other than the employers or the unions.

(bb) Notwithstanding any other provision of law to the contrary, coverage of dependent children or grandchildren for excepted benefits and for benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103 shall be controlled by this Subitem with regard to requirements for age. For excepted benefits, as defined in R.S. 22:1061(3)(b) and (c) and for benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103, the following requirements for coverage of dependent children or grandchildren shall apply:

(I) To an unmarried dependent child or grandchild but who is not a full-time student until the age of twenty-one. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(II) To an unmarried dependent child or grandchild who is enrolled as a full-time student until the age of twenty-four. This enrollment may be at an accredited college or university or at a vocational, technical, vocational-technical, or trade school or institute. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(III) To an unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder which renders the child or grandchild, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the health insurance issuer or health maintenance organization, unable to attend school as a full-time student and from holding self-sustaining employment, until the age of twenty-four. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(IV) To an unmarried dependent child or grandchild who is incapable of self-sustaining employment by reason of intellectual or physical disability, who became incapable prior to attainment of the age of twenty-one, there may be continuous coverage for excepted benefits regardless of age. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(b) The benefits payable under any policy or contract of group health and accident insurance shall be payable to the employee, members or employees of members of

multiple associations or to some beneficiary or beneficiaries designated by him, other than the employer or association or multiple associations, but if there is no designated beneficiary as to all or any part of the insurance at the death of the employee, member or employee of members, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee, member or employee of members, 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, member or employee of members: 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) Except as may otherwise be provided in the policy or contract of group health and accident insurance or by R.S. 22:1012, the policyholder and the insurer may agree to modify, amend, or cancel the group policy, and such agreement shall be binding upon the employee, member, or employee of members 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. 22:887(F).

(d) 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, member's, or member's employee's coverage terminated for failure of the employee, member, or employee of members to maintain eligibility as provided in the policy or contract of group health and accident insurance.

(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) 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 children until the age of twenty-six, and grandchildren until the age of twenty-six who are in the legal custody of and residing with the grandparent pursuant to R.S. 22:1003 and 1003.1, except that the policy may provide for continuing coverage for any child or grandchild in the legal custody of and residing with the grandparent who is incapable of self-sustaining employment by reason of intellectual or physical

disability, who became so incapable prior to attainment of age twenty-six, 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 to the policy, shall constitute the entire contract between the parties.

(b) Notwithstanding any other provision of law to the contrary, coverage of dependent children or grandchildren for excepted benefits and for benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103 shall be controlled by this Subparagraph with regard to requirements for age. For excepted benefits, as defined in R.S. 22:1061(3)(b) and (c) and for benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103, the following requirements for coverage of dependent children or grandchildren shall apply:

(i) To an unmarried dependent child or grandchild who is not a full-time student until the age of twenty-one. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(ii) To an unmarried dependent child or grandchild who is enrolled as a full-time student until the age of twenty-four. This enrollment may be at an accredited college or university or at a vocational, technical, vocational-technical, or trade school or institute. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(iii) To an unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder which renders the child or grandchild, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the health insurance issuer or health maintenance organization, unable to attend school as a full-time student and from holding self-sustaining employment, until the age of twenty-four. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(iv) To an unmarried dependent child or grandchild who is incapable of self-sustaining employment by reason of intellectual or physical disability, who became so incapable prior to attainment of the age of twenty-one, there may be continuous coverage for excepted benefits regardless of age. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(3) Blanket health and accident insurance is any policy covering special groups of persons as enumerated in any of the following:

(a) Under a policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation that operates as a common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier or means of transportation.

(b) Under a policy issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents, or guests defined by reference to hazards incident to activities or operations of the policyholder.

(c) Under a policy issued to a college, school, or other institution of learning, a school district or districts or school jurisdictional unit, or to the head, principal, or governing board thereof, who or which shall be deemed the

policyholder, covering students, teachers, employees, or volunteers.

(d) Under a policy issued in the name of any volunteer or governmental fire department, first aid, civil defense, or other such volunteer group, which shall be deemed the policyholder, covering any group of members, participants, or volunteers incident to any activities or operations sponsored or supervised by 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 or contract issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, supervisors, or volunteers.

(g) Under a policy or contract issued to a religious, charitable, recreational, educational, or civic organization or branch thereof, which shall be deemed the policyholder, covering any group of members, participants, or volunteers defined by reference to specified hazards incident to any activities or operations sponsored or supervised by or on the premises of such policyholder.

(h) Under a policy or contract issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

(i) Under a policy or contract issued to a restaurant, hotel, motel, resort, innkeeper, or other group with a high degree of potential customer liability, which shall be deemed the policyholder, covering patrons, guests, or volunteers.

(j) Under a policy or contract issued to a health maintenance organization, a health care provider, or other arranger of health services, which shall be deemed the policyholder, covering subscribers, patients, donors, and surrogates, provided that the coverage is not made a condition of receiving care or that major medical health and accident coverage may not be provided to subscribers or other enrollees pursuant to this Section.

(k) Under a policy or contract issued to a bank or other financial association or institution, vendor, or to a parent holding company or to the trustee, trustees, or agent designated by one or more banks or other financial associations or institutions or vendors under which account holders, credit card holders, debtors, guarantors, or purchasers are insured.

(l) Under a policy or contract issued to an incorporated or unincorporated association of persons having a common interest or calling, formed for purposes other than obtaining insurance, which association shall be deemed the policyholder, covering members or participants of such association.

(m) Under a policy or contract issued to a travel agency or other organization that provides travel related services, which organization shall be deemed the policyholder, to cover all persons for which travel related services are provided.

(n) Under a policy issued to any other risk or class of risks that, in the discretion of the commissioner of insurance, may be subject to the issuance of a blanket health and accident policy. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

(o) 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.

(4) 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 that 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 is a minor such benefits may be made payable to his parent, guardian, or other person actually supporting him.

B. (1) The term "employees" as used in this Section shall be deemed to include, for the purposes of insurance under this Section 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.

(2) As used in this Section, "participating association" shall mean an association that has, by virtue of an affirmative vote, consensus, or similar decision in accordance with the association's bylaws or conventions, acted overtly through its staff or elected leaders, acting within the scope of their authority, to enter into an agreement with one or more other associations to be a partner in a multiple association trust on terms mutually agreeable to all associations participating in the multiple association trust.

C. Insurers issuing policies under this Section shall be subject to all the other applicable provisions of this Subpart and R.S. 22:984, 1061 through 1079, and 2247. 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 at the end of the first year or of any subsequent year of insurance, 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 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, [1] 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.

Renumbered from R.S. 22:215 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. 717, § 1; Acts 1997, No. 1138, § 1, eff. July 14, 1997; Acts 1997, No. 1175, § 1; Acts 1999, No. 30, § 1; Acts 1999, No. 474, § 1; Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2004, No. 325, § 1, eff. June 18, 2004; Acts 2004, No. 751, § 1; Acts 2010, No. 896, § 1; Acts 2010, No. 912, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2011, No. 360, § 1, eff. June 29, 2011; Acts 2013, No. 201, § 1; Acts 2014, No. 811, § 11, eff. June 23, 2014.

[1] 29 U.S.C.A. 1167(1).

§ 1001. Mandatory coverage and continued coverage of children with physical or mental disabilities 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 of this Section 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 disability, 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.

Renumbered from R.S. 22:215.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1973, No. 99, §§ 1, 2. Amended by Acts 1974, No. 534, § 1; Acts 2014, No. 811, § 11, eff. June 23, 2014.

§ 1002. Coverage of unmarried dependent children and grandchildren by the Office of Group Benefits

A. Notwithstanding any other provision of law to the contrary, and in particular the provisions of R.S. 22:1001, 1003, and 1003.1, coverage of dependent children or grandchildren by the Office of Group Benefits shall be controlled by this Section as to limitations relative to age, marital status, and full-time student status.

B. Except as otherwise provided by Subsection D of this Section, for those dependent children or grandchildren who are unmarried but who are not full-time students, coverage shall extend to those under the age of twenty-one years.

C. For those dependent children or grandchildren who are unmarried but who are full-time students, coverage shall extend to those under the age of twenty-four years.

D. Coverage for an unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder which renders the child or grandchild, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the Office of Group Benefits, unable to attend school as a full-time student and from holding self-sustaining employment shall extend until the child or grandchild reaches the age of twenty-four years.

E. (1) Unmarried dependent children who are enrolled as students at an accredited college or university or at a vocational, technical, vocational-technical, or trade school or institute on a full-time basis shall be considered as full-time students for purposes of coverage by the Office of Group Benefits.

(2) In order to qualify for coverage as a dependent of a grandparent, an unmarried child must be in the legal custody of and reside with the grandparent.

Renumbered from R.S. 22:215.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1974, No. 148, § 1. Amended by Acts 2010, No. 912, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1003. Coverage of children for group and individual health and accident insurance; exception

A. (1) Children, including a grandchild in the legal custody of and residing with a grandparent, until the age of twenty-six shall be considered as dependents of

the primary insured or enrollee under the provisions of any family group health and accident insurance policy, group health and accident insurance policy, or similar coverage issued by a health maintenance organization in this state.

(2) Notwithstanding any other provision of law to the contrary, coverage of dependent children or grandchildren for excepted benefits and for benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103 shall be controlled by this Paragraph with regard to requirements for age. For excepted benefits, as defined in R.S. 22:1061(3)(b) and (c) and for benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103, the following requirements for coverage of dependent children or grandchildren shall apply:

(a) To an unmarried dependent child or grandchild who is not a full-time student until the age of twenty-one. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(b) To an unmarried dependent child or grandchild who is enrolled as a full-time student until the age of twenty-four. This enrollment may be at an accredited college or university or at a vocational, technical, vocational-technical, or trade school or institute. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(c) To an unmarried dependent child or grandchild who is a full-time student and who develops a mental or nervous condition, problem, or disorder which renders the child or grandchild, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by the insurer or health maintenance organization, unable to attend school as a full-time student and from holding self-sustaining employment, until the age of twenty-four. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

(d) To an unmarried dependent child or grandchild who is incapable of self-sustaining employment by reason of intellectual or physical disability, who became incapable prior to attainment of the age of twenty-one, there may be continuous coverage for excepted benefits regardless of age. A dependent grandchild shall be in the legal custody of and residing with the grandparent.

B. For group plans in existence before March 23, 2010, only, the provisions of this Section shall apply only if the child is not eligible to enroll in an eligible employer-sponsored health plan. The provisions of this Subsection shall not apply for plan years beginning after January 1, 2014.

C. The provisions of this Section shall apply to all policies issued or renewed or issued for delivery in this state after September 23, 2010, except that these provisions, in reference to age requirements, shall not apply to excepted benefits as defined in R.S. 22:1061(3)(b) and (c) and to benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103.

Renumbered from R.S. 22:215.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1974, No. 505, § 1. Amended by Acts 1997, No. 1175, § 1; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2010, No. 912, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2011, No. 360, § 1, eff. June 29, 2011; Acts 2014, No. 811, § 11, eff. June 23, 2014.

§ 1003.1. Children; portability; enrollment; exception

A. In reference to R.S. 22:1003, the following shall apply:

(1) The health insurance issuer or health maintenance organization shall apply portability rights in reference to preexisting conditions to the newly added child or grandchild as described in R.S. 22:1062(A) and (B). The preexisting condition waiting period applicable to such child or grandchild shall be applied to the child or grandchild in the same manner as any other dependent.

(2) The health insurance issuer or health maintenance organization shall offer to all insureds or enrollees a special enrollment period of not less than thirty days beginning on September 23, 2010, to include a child or grandchild under the age of twenty-six as a new entrant covered under the policy or subscriber agreement. It is solely the insured's or enrollee's decision whether to add such child or grandchild to the policy or subscriber agreement.

(3) The health insurance issuer or health maintenance organization shall not limit or otherwise restrict the offer of coverage to a child or grandchild until the age of twenty-six by requiring any of the following:

(a) That the child or grandchild had to have been previously covered as a dependent.

(b) That the child or grandchild resides in this state.

(c) That the child or grandchild demonstrate that he had previous creditable coverage.

(d) That the enrollee or insured requested coverage for the child or grandchild the first time such child or grandchild was eligible for coverage.

(4) The health insurance issuer or health maintenance organization may not deny coverage to a child or grandchild under the age of twenty-six when the enrollee or insured requests coverage.

(5) The health insurance issuer or health maintenance organization shall offer coverage for an enrollee's or insured's children or grandchildren under the age of twenty-six as new entrants through special enrollment and shall annually provide at least a thirty-day enrollment period. The health insurance issuer or health maintenance organization may request documentation of such child's or grandchild's creditable coverage to determine portability.

B. For group plans in existence before March 23, 2010, only, the provisions of this Section shall apply only if the child is not eligible to enroll in an eligible employer-sponsored health plan. The provisions of this Subsection shall not apply for plan years beginning after January 1, 2014.

C. The provisions of this Section shall apply to all policies or subscriber agreements issued or renewed or issued for delivery in this state after September 23, 2010; except that these provisions, in reference to age requirements, shall not apply to excepted benefits as defined in R.S. 22:1061(3)(b) and (c) and to benefits of short-term, limited duration insurance as defined pursuant to 45 CFR 144.103.

Added by Acts 2010, No. 912, § 1. Amended by Acts 2011, No. 360, § 1, eff. June 29, 2011.

§ 1004. 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 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 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 Titles XI, XII, or XII-A of the Louisiana Children's Code, 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.

Renumbered from R.S. 22:227 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 746, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1005. 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 Subpart, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, and nonfederal government plans subject to the provisions of Subpart B of Part II of Chapter 6 of this Title, 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. 22:1871 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. 22:1871 et seq.

Renumbered from R.S. 22:230.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 504, § 1, eff. June 25, 2004.

§ 1006. 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 provision 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 R.S. 22:984, 1061 through 1079, and 2247, and reasonable regulations issued by the commissioner of insurance under the Administrative Procedure Act[1] 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 provide 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.

Renumbered from R.S. 22:215.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1977, No. 332, § 1. Amended by Acts 1992, No. 342, § 1; Acts 1992, No. 534, § 1; Acts 1993, No. 473, § 1; Acts 1997, No. 1138, § 1, eff. July 14, 1997; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

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

§ 1006.1. Prior authorization forms required; criteria

A. As used in this Section:

(1) "Health benefit plan", "plan", "benefit", or "health insurance coverage" means services 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, excepted benefits are not included as a "health benefit plan".

(2) "Health insurance issuer" means any entity that offers health insurance coverage through a plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. "Health insurance issuer" shall also include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title.

(3) "Prior authorization" shall mean a utilization management criterion utilized to seek permission or waiver of a drug to be covered under a health benefit plan that provides prescription drug benefits.

(4) "Prior authorization form" shall mean a standardized, uniform application developed by a health insurance issuer for the purpose of obtaining prior authorization.

B. Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on and after January 1, 2013, a health insurance issuer shall utilize only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. The form shall not exceed two pages in length, excluding any instructions or guiding documentation. A health insurance issuer may make the form accessible through multiple computer operating systems. Additionally, the health insurance issuer shall submit its prior authorization forms to the Department of Insurance to be kept on file on or after January 1, 2013. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the Department of Insurance within fifteen days prior to use or implementation of such replacements or modifications.

Added by Acts 2012, No. 318, § 1, eff. May 25, 2012.

§ 1007. 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. 22:1028.

(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. 40:1231.1(A), 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. Notwithstanding any provision of law to the contrary, any contract or agreement between a managed care organization and a health care provider shall include provisions that establish the reimbursement of a health care provider in an instance in which the managed care organization requests or requires substitution of a medication for an enrollee and the provider has executed the requested or

required substitution. The provisions of this Section shall not apply to generic substitution or step therapy programs utilized by the managed care organization or its delegated entity that promote generic drugs as a first-line therapy.

J. Any contract provision, written policy, or written procedure in violation of this Section shall be deemed to be unenforceable and null and void.

Renumbered from R.S. 22:215.18 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1232, § 1. Amended by Acts 2001, No. 1198, § 1, eff. June 29, 2001; Acts 2014, No. 396, § 1, eff. Jan. 1, 2015.

§ 1008. 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.

Renumbered from R.S. 22:215.19 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 897, § 1.

§ 1009. Health care provider credentialing

A. As used in this Section, the following words and phrases 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, a dentist licensed

to practice dentistry by the Louisiana State Board of Dentistry, or other individual health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(6) "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.

(7) "Health insurance issuer" or "issuer" means any insurer who offers health insurance coverage through a plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. A "health insurance issuer" or "issuer" shall also include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, a dental benefit plan, including an entity defined as a dental service contractor in Subpart G of this Part, and shall include the Office of Group Benefits programs.

(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.

(5) A provider who has been credentialed by a health insurance issuer for any location in the state of Louisiana and is current on all credentialing at such location or locations, shall be considered credentialed for all other locations at which that provider may legally practice medicine or dentistry in the state of Louisiana, provided that each of the following conditions are met:

(a) Not less than thirty days prior to the time at which the provider begins practicing at any additional location, another provider who is current on all credentialing with that health insurance issuer legally practiced there.

(b) The provider gives the health insurance issuer written notice of any additional location of practice beyond his primary practice location and any additional practice location originally noted on the provider's initial credentialing application form. The health insurance issuer may require that such notice include such additional information as may be reasonably necessary in order to process claims filed by the provider from the additional location. The credentialing of the provider for any additional location shall be effective immediately upon the receipt by the health insurance issuer of such written notice from the provider.

(6) Pursuant to Paragraph (5) of this Subsection, there shall be no other requirements placed upon the provider in order to be credentialed by a health insurance issuer for any additional location.

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.

Renumbered from R.S. 22:11.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 671, § 1, eff. Nov. 1, 2004. Amended by Acts 2005, No. 374, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2015, No. 63, § 1, eff. June 5, 2015.

§ 1010. 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.

Renumbered from R.S. 22:225 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1984, No. 444, § 1.

§ 1011. 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.

Renumbered from R.S. 22:226 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 481, § 1.

§ 1012. 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 R.S. 22:984, 1061 through 1079, and 2247.

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 disability which renders a person incapable of self-employment, provided that the person with a disability 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. 22:1091 through 1095.

D. This Section shall not be construed to prohibit an insurer from discontinuing health insurance coverage pursuant to R.S. 22:1068 and 1074.

Renumbered from R.S. 22:228 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 269, § 1. Amended by 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; Acts 2014, No. 811, § 11, eff. June 23, 2014.

§ 1013. 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 subdivision 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.

Renumbered from R.S. 22:228.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 890, § 1.

§ 1014. Limitations on health insurance coverage of elective abortions in the state exchange prohibited

A. The legislature finds and declares all of the following:

(1) Federal funding for insurance plans that cover abortions is prohibited by the Hyde Amendment and the Federal Employee Health Benefits Program (FEHBP).

(2) Congress enacted and the president signed into law the Patient Protection and Affordable Care Act of 2010, P.L. 111-148.

(3) In the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, states are explicitly permitted to pass laws prohibiting qualified health plans offered through an exchange in their state from offering abortion coverage.

(4) It is the longstanding policy of this state that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and constitution of this state. Further, the legislature finds and declares that the longstanding policy of this state is to protect the right to life of the unborn child from conception by prohibiting abortion impermissible only because of the decisions of the United States Supreme Court and that, therefore, if those decisions of the United States Supreme Court are ever reversed or modified or the United States Constitution is amended to allow protection of the unborn then the former policy of this state to prohibit abortions shall be enforced.

B. No health care plan required to be established in this state through an exchange pursuant to federal health reform legislation enacted by the 111th Congress shall offer coverage for abortion services. As used in this Section, "abortion" shall have the same meaning as defined in R.S. 40:1061.9(1).

Added by Acts 2010, No. 941, § 1, eff. July 2, 2010.

§ 1015. 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 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.

Renumbered from R.S. 22:646 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1016. Regulation by the Department of Insurance and the Department of Health and Hospitals of prepaid entities participating in the Louisiana Medicaid Program

A. Notwithstanding any law to the contrary, any prepaid entity that participates in the Louisiana Medicaid Program is required to obtain an insurer license or certificate of authority from the Louisiana Department of Insurance. Such a prepaid entity participating in the Louisiana Medicaid Program shall be regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program, be regulated by the Louisiana Department of Health and Hospitals, subject to 42 USCA § 1396 et seq., and all applicable federal and state laws, rules, and regulations relating to the Louisiana Medicaid Program. The Louisiana Department of Health and Hospitals

shall have the authority to adopt and promulgate such rules and regulations, including certification, relating to the Louisiana Medicaid Program. Except for licensure and financial solvency requirements, no other provisions of this Title shall apply to a prepaid entity with respect to the participation of the prepaid entity in the Louisiana Medicaid Program.

B. As used in this Section, "prepaid entity" shall mean any organization paid on a per-person per-month basis for the provision of services to Medicaid eligible beneficiaries, when such organization has entered into a contract with the Department of Health and Hospitals assuming the financial obligation to pay for such services.

Added by Acts 2010, No. 1, § 1, eff. April 29, 2010.

§ 1017. Wellness or health improvement programs

A. A health insurance issuer may offer a voluntary wellness or health improvement program that allows for rewards or incentives including but not limited to merchandise, gift cards, debit cards, premium discounts or rebates, contributions toward a member's health savings account, modifications to copayment, deductible, or coinsurance amounts, or any combination of these incentives to encourage participation or to reward for participation in the program.

B. Any reward or incentive established under this Section shall not violate Part IV of Chapter 7 of this Title if disclosed in the policy or certificate of authority of the health insurance issuer and filed with the Department of Insurance in accordance with existing state requirements.

C. The insured or enrollee may be required to provide verification, such as a statement from his physician, that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness or health improvement program.

D. Nothing in this Section shall prohibit health insurance issuers from offering incentives or rewards to members for adherence to wellness or health improvement programs if otherwise allowed by state or federal law.

E. As used in this Section, "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 Section, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of Part II of Chapter 6 of this Title, and the Office of Group Benefits.

Added by Acts 2010, No. 280, § 1, eff. June 17, 2010.

§ 1018. Choice in obtaining health insurance coverage

A. It is hereby declared that the public policy of this state, consistent with our constitutionally recognized and inalienable right of liberty, is that every person within this state is and shall be free from governmental intrusion in choosing or declining to choose any mode of securing health insurance coverage without penalty or threat of penalty.

B. No resident of this state, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the state or the federal government, shall be required to obtain or maintain a policy of individual health insurance coverage. The state shall not impose a penalty or fee on any resident of the state for failure to obtain or maintain health insurance coverage.

C. No provision in this Section shall be interpreted or held to supercede any provision of the Patient Protection and Affordable Care Act of 2010, P.L. 111-148 or any other federal law.

Added by Acts 2010, No. 952, § 1.

SUBPART A-1. NETWORK ADEQUACY ACT

§ 1019.1. Short title; purpose; scope; definitions

A. This Subpart shall be known and may be cited as the "Network Adequacy Act".

B. The purpose and intent of this Subpart is to establish standards for the creation and maintenance of networks by health insurance issuers and to ensure the adequacy, accessibility, and quality of health care services offered to covered persons under a health benefit plan by establishing requirements for written agreements between health insurance issuers offering health benefit plans and participating providers regarding the standards, terms, and provisions under which such participating providers will provide services to covered persons.

C. This Subpart shall apply to all health insurance issuers that offer health benefit plans but shall not include excepted benefits policies as defined in R.S. 22:1061(3).

D. As used in this Subpart:

(1) "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.

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

(3) "Contracted reimbursement rate" means the aggregate maximum amount that a participating or contracted health care provider has agreed to accept from all sources for payment of covered health care services under the health insurance coverage applicable to the covered person.

(4) "Covered health care services" means health care services that are either covered and payable under the terms of health insurance coverage or required by law to be covered.

(5) "Covered person" means a policyholder, subscriber, enrollee, insured, or other individual participating in a health benefit plan.

(6) "Emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(7) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(8) "Essential community providers" means providers that serve predominantly low-income, medically underserved individuals, including those providers defined in Section 340B(a)(4) of the Public Health Service Act and providers described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by Section 221 of Public Law 111-8.

(9) "Facility-based physician" means a physician licensed to practice medicine who is required by the base health care facility to provide services in a base health care facility, including an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care services related to any medical condition.

(10) "Health benefit plan" means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(11) "Health care 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 centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(12) "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.

(13) "Health care provider" or "provider" means a health care professional or a health care facility.

(14) "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.

(15) "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 health benefit plan.

(16) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner,

that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, or any other entity providing a plan of health insurance or health benefits.

(17) "Network of providers" or "network" means an entity, including a health insurance issuer, that, through contracts or agreements with health care providers, provides or arranges for access by groups of covered persons to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(18) "Participating provider" or "contracted health care provider" means a health care provider who, under a contract or agreement with the health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than in-network coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

(19) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination thereof.

(20) "Primary care professional" means a participating health care professional designated by a health insurance issuer to supervise, coordinate, or provide initial care or continuing care to covered persons, and who may be required by the health insurance issuer to initiate a referral for specialty care and maintain supervision of health care services rendered to covered persons.

Added by Acts 2013, No. 205, § 1, eff. June 10, 2013.

§ 1019.2. Network adequacy

A. A health insurance issuer providing a health benefit plan shall maintain a network that is sufficient in numbers and types of health care providers to ensure that all health care services to covered persons will be accessible without unreasonable delay. In the case of emergency services and any ancillary emergency health care services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this Subpart. In determining sufficiency criteria, such criteria shall include but not be limited to ratios of health care providers to covered persons by specialty, ratios of primary care providers to covered persons, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

B. (1) Each health insurance issuer shall maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.

(2) A health insurance issuer shall establish and maintain adequate arrangements

to ensure reasonable proximity of participating providers to the primary residences of covered persons. In determining whether a health insurance issuer has complied with this Paragraph, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration and the geographic composition of the service area. The commissioner may consider a health insurance issuer's adjacent service area networks that may augment health care providers if a health care provider deficiency exists within the service area.

(3) A health insurance issuer shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted health care services to covered persons.

(4) A health insurance issuer shall maintain a directory of its network of providers on the Internet. The directory of network providers must be furnished in printed form to any covered person upon request. The directory of network providers shall identify all health care providers that are not accepting new referrals of covered persons or are not offering services to covered persons.

(5)(a) Beginning January 1, 2014, except as otherwise provided in Subparagraph (b) of this Paragraph, a health insurance issuer shall annually file with the commissioner, an access plan meeting the requirements of this Subpart for each of the health benefit plans that the health insurance issuer offers in this state. Any existing, new, or initial filing of policy forms by a health insurance issuer shall include the network of providers, if any, to be used in connection with the policy forms. If benefits under a health insurance policy do not rely on a network of providers, the health insurance issuer shall state such fact in the policy form filing. The health insurance issuer may request the commissioner to deem sections of the access plan to contain proprietary or trade secret information that shall not be made public in accordance with the Public Records Law, R.S. 44:1 et seq., or to contain protected health information that shall not be made public in accordance with R.S. 22:42.1. If the commissioner concurs with the request, those sections of the access plan shall not be subject to the Public Records Law or shall not be made public in accordance with R.S. 22:42. 1 as applicable. The health insurance issuer shall make the access plans, absent any such proprietary or trade secret information and protected health information, available and readily accessible on its business premises and shall provide such plans to any interested party upon request, subject to the provisions of the Public Records Law and R.S. 22:42.1.

(b) In lieu of meeting the filing requirements of Subparagraph (a) of this Paragraph, a health insurance issuer shall, beginning January 1, 2014, except as otherwise provided in Subparagraph (c) of this Paragraph, submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission, Inc./URAC to the commissioner, including an affidavit and sufficient proof demonstrating its accreditation for compliance with the network adequacy requirements of this Subpart. The affidavit shall include sufficient information to notify the commissioner of the health insurance issuer's accreditation and shall include a certification that the health insurance issuer's network of providers includes health care providers that specialize in mental health and substance abuse services and providers that are essential community providers. The affidavit shall also certify that the health insurance issuer complies with the provider directory requirement contained in Paragraph (4) of this Subsection. The commissioner may, at any

time, recognize accreditation by any other nationally recognized organization or entity that accredits health insurance issuers; however, such entity's accreditation process shall be equal to or have comparative standards for review and accreditation of network adequacy.

(c) A health insurance issuer that has submitted an application for accreditation to NCQA or URAC prior to December 31, 2013, but has not yet received such accreditation by January 1, 2014, shall be deemed accredited for the purposes of this Subpart upon submission of an affidavit to the commissioner by January 1, 2014, demonstrating that the issuer is in the process of accreditation. Upon receipt of accreditation, the issuer shall submit proof of such accreditation to the commissioner pursuant to Subparagraph (b) of this Paragraph. However, in the event that the issuer withdraws its application for accreditation or does not receive accreditation prior to July 1, 2015, such issuer shall file an access plan with the commissioner pursuant to Subparagraph (a) of this Paragraph within sixty days of such withdrawal or denial.

(d) If a health insurance issuer that has submitted proof of accreditation to the commissioner subsequently loses such accreditation, the issuer shall promptly notify the commissioner and file an access plan with him pursuant to Subparagraph (a) of this Paragraph within sixty days of the loss of such accreditation.

(e) A health insurance issuer submitting proof of accreditation or an affidavit demonstrating that the issuer is in the process of accreditation shall maintain an access plan at its principal place of business. Such access plan shall be in accordance with the requirements of the accrediting entity.

C. A health insurance issuer not submitting proof of accreditation shall file an access plan for written approval from the commissioner for existing health benefit plans and prior to offering a new health benefit plan. Additionally, such a health insurance issuer shall inform the commissioner when the issuer enters a new service or market area and shall submit an updated access plan demonstrating that the issuer's network in the new service or market area is adequate and consistent with this Subpart. Each such access plan, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page of the form. Such a health insurance issuer shall update an existing access plan whenever it makes any material change to an existing health benefit plan. Such an access plan shall describe or contain, at a minimum, each of the following:

(1) The health insurance issuer's network which includes but is not limited to the availability of and access to centers of excellence for transplant and other medically intensive services as well as the availability of critical care services, such as advanced trauma centers and burn units.

(2) The health insurance issuer's procedure for making referrals within and outside its network.

(3) The health insurance issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans and general provider availability in a given geographic area.

(4) The health insurance issuer's efforts to address the needs of covered persons

with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, or with physical and mental disabilities.

(5) The health insurance issuer's methods for assessing the health care needs of covered persons and their satisfaction with services.

(6) The health insurance issuer's method of informing covered persons of the health benefit plan's services and features, including but not limited to the health benefit plan's utilization review procedure, grievance procedure, external review procedure, process for choosing and changing providers, and procedures for providing and approving emergency services and specialty care. Additional information relating to these processes shall be available upon request and accessible via the health insurance issuer's website.

(7) The health insurance issuer's system for ensuring coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary health care services, including social services and other community resources, and for ensuring appropriate discharge planning.

(8) The health insurance issuer's processes for enabling covered persons to change primary care professionals, for medical care referrals, and for ensuring that participating providers that require the use of health care facilities have hospital admission privileges.

(9) The health insurance issuer's proposed plan for providing continuity of care in the event of contract termination between the health insurance issuer and any of its participating providers, as required by R.S. 22:1005, or in the event of the health insurance issuer's insolvency or other inability to continue operations. This description shall explain how covered persons will be notified of contract termination, including but not limited to the effective date of the contract termination, the health insurance issuer's insolvency, or other cessation of operations, and how such covered persons will be transferred to other providers in a timely manner.

(10) A geographic map of the area proposed to be served by the health benefit plan by both parish and zip code.

(11) The policies and procedures to ensure access to covered health care services under each of the following circumstances:

(a) When the covered health care service is not available from a participating provider in any case when a covered person has made a good faith effort to utilize participating providers for a covered service and it is determined that the health insurance issuer does not have the appropriate participating providers due to insufficient number, type, or distance, the health insurance issuer shall ensure, by terms contained in the health benefit plan, that the covered person will be provided the covered health care service.

(b) When the covered person has a medical emergency within the network's service area.

(c) When the covered person has a medical emergency outside the network's service area.

(12) Any other information required by the commissioner to determine compliance with the provisions of this Subpart.

D. A health insurance issuer not submitting proof of accreditation shall file any proposed material changes to the access plan with the commissioner prior to implementation of any such changes. The removal or withdrawal of any hospital or multi-specialty clinic from a health insurance issuer's network shall constitute a material change and shall be filed with the commissioner in accordance with the provisions of this Subpart. Changes shall be deemed approved by the commissioner after sixty days unless specifically disapproved in writing by the commissioner prior to expiration of such sixty days.

E. All filings containing any proposed material changes to an access plan as required by this Subpart shall include but not be limited to each of the following:

(1) A listing of health care facilities and the number of hospital beds at each network health care facility.

(2) The ratio of participating providers to current covered persons.

(3) Any other information requested by the commissioner.

Added by Acts 2013, No. 205, § 1, eff. June 10, 2013.

§ 1019.3. Enforcement provisions; penalties; regulations

A. If the commissioner determines that a health insurance issuer has not contracted with enough participating providers to ensure that covered persons have accessible health care services in a geographic area, that a health insurance issuer's access plan does not ensure reasonable access to covered health care services, or that a health insurance issuer has entered into a contract that does not comply with this Subpart, the commissioner may do either or both of the following:

(1) Institute a corrective action plan that shall be followed by the health insurance issuer within thirty days of notice of noncompliance from the commissioner.

(2) Use his other enforcement powers to obtain the health insurance issuer's compliance with this Subpart, including but not limited to disapproval or withdrawal of his approval.

B. The commissioner shall not act to arbitrate, mediate, or settle disputes regarding a decision not to include a health care provider in a health benefit plan or in a provider network if the health insurance issuer has an adequate network as determined by the commissioner pursuant to the requirements contained in this Subpart.

C. The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Subpart. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

D. (1) The commissioner may issue, and cause to be served upon the health insurance issuer violating this Subpart, an order requiring such health insurance issuer to cease and desist from such act or omission for the whole state or any geographic area.

(2) The commissioner may refuse to renew, suspend, or revoke the certificate of authority of any health insurance issuer violating any of the provisions of this Subpart, 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 health insurance issuer, up to one hundred thousand dollars aggregate for all violations in a calendar year per health insurance issuer, when such violations, in his opinion, after a proper hearing, warrant the refusal, suspension, or revocation of such certificate, or the imposition of a fine. The commissioner of insurance is authorized to withhold fines imposed under this Subpart. Such hearing shall be held in the manner provided in Chapter 12 of this Title, R.S. 22:2191 et seq. Additionally, the commissioner may take any other administrative action, including imposing those fines and penalties enumerated in R.S. 22:18.

Added by Acts 2013, No. 205, § 1, eff. June 10, 2013.

SUBPART B. STATE MANDATED HEALTH BENEFITS

§ 1021. 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. 22:839, miscellaneous insurance contract authorized by R.S. 22:47(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.

Renumbered from R.S. 22:213.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1974, No. 544, § 1. Amended by Acts 1989, No. 817, § 1.

§ 1022. 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.

Renumbered from R.S. 22:213.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1418, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003.

§ 1023. 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)(a) "Genetic information" means all information about genes, gene products, inherited characteristics, or family history/pedigree that is expressed in common language and shall include each of the following:

(i) An individual's genetic test.

(ii) The genetic tests of the family members of an individual.

(iii) The manifestation of a disease or disorder in family members of an individual.

(iv) With respect to an individual or family member of an individual who is a pregnant woman, genetic information of any fetus or embryo carried by such pregnant woman; and with respect to an individual or family member of an individual utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

(b) "Genetic information" shall not mean information about the sex or age of any individual.

(9)(a) "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 or that detects genotypes, mutation, or chromosomal changes.

(b) "Genetic test" shall not mean an analysis of proteins or metabolites that either:

(i) Does not detect genotypes, mutations, or chromosomal changes.

(ii) Is directly related to a manifested disease, disorder, or pathological condition that could be reasonably detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(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.

(16) "Genetic services" means a genetic test, genetic counseling, including obtaining, interpreting, or assessing genetic information, or genetic education.

(17) "Underwriting purposes" means rules for or determination of eligibility, including enrollment and continued eligibility, for benefits under the plan or coverage; the computation of premium or contribution amounts under the plan or coverage; and other activities related to the creation, renewal, or replacement of a contract or policy issued by an insurer.

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.

(4)(a) No insurer shall request, require, or purchase genetic information either:

(i) Of an individual or family member of an individual for underwriting purposes.

(ii) With respect to any individual or family member of an individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(b) If an insurer offering health insurance coverage in the individual or group market obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Item (a)(ii) of this Paragraph if such request, requirement, or purchase is not in violation of Item (a)(i) of this Paragraph.

(5)(a) No insurer shall request or require that an individual, a family member of such individual, or a group member undergo a genetic test.

(b) Subparagraph (a) of this Paragraph shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(6)(a) No insurer shall establish rules for eligibility, including continued eligibility, of any individual or an individual's family member to enroll or continue enrollment based on genetic information.

(b) Nothing in Subparagraph (a) of this Paragraph or in Items (4)(a)(i) and (ii) of this Subsection shall be construed to preclude an insurer from establishing rules for eligibility for an individual to enroll in individual health insurance coverage based on the manifestation of a disease or disorder in that individual or in a family member of such individual where such family member is covered under the policy that covers such individual.

(7)(a) No insurer shall impose any preexisting condition exclusion on the basis of genetic information of an individual, family member of an individual, or group member.

(b) Nothing in Subparagraph (a) of this Paragraph or in Items (4)(a)(i) and (ii) of this Subsection shall be construed to preclude an insurer offering coverage in the individual market from imposing any preexisting condition exclusion for an individual with respect to health insurance coverage on the basis of a manifestation of a disease or disorder in that individual.

(8)(a) No insurer shall adjust premium or contribution amounts for an individual or group health plan on the basis of genetic information concerning the individual or a family member of the individual.

(b) Nothing in Subparagraph (a) of this Paragraph shall be construed to preclude an insurer offering health insurance coverage in the individual market from adjusting premium or contribution amounts for an individual on the basis of a manifestation of a disease or disorder in that individual, or in a family member of such individual where such family member is covered under the policy that covers such individual. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other individuals covered under the policy issued to such individual and to further increase premium or contribution amounts.

(c) Nothing in Subparagraph (a) of this Paragraph shall be construed to preclude an insurer offering health insurance coverage in connection with a group health plan from increasing the premium for an employer based upon the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(9)(a) Nothing in Subparagraph (5)(a) of this Subsection shall be construed to preclude an insurer offering health insurance coverage in the individual or group market from obtaining and using the results of a genetic test in making a determination regarding payment, as such term is defined for the purposes of applying the regulations promulgated by the secretary of the United States Department of Health and Human Services under Part C of Title XI of the Social Security Act and Section 264 of the Health Insurance Portability and Accountability Act of 1996, consistent with Paragraphs (6) and (7) of this Subsection.

(b) For purposes of Subparagraph (a) of this Paragraph, an insurer offering health insurance coverage in the individual or group market may request only the minimum amount of information necessary to accomplish the intended purpose.

(10) Notwithstanding Subparagraph (5)(a) of this Subsection, an insurer offering health insurance coverage in the individual or group market may request, but not require, that an individual, family member of an individual, or a group member undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(b) The insurer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made both that:

(i) Compliance with the request is voluntary.

(ii) Noncompliance will have no effect on enrollment status or premium, or

contribution amounts.

(c) No genetic information collected or acquired under this Paragraph shall be used for underwriting purposes.

(d) The insurer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this Paragraph, including a description of the activities conducted.

(e) The insurer complies with such other conditions as the secretary of the United States Department of Health and Human Services may by regulation require for activities conducted under this Paragraph.

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.

(6) Nothing in this Section shall exempt a covered entity from the requirements of the Health Insurance Portability and Accountability Act of 1996 pertaining to

the collection, use, or disclosure of genetic information, which for purposes of the Health Insurance Portability and Accountability Act of 1996, is defined as "health information" under 42 U.S.C. § 1320d(4)(b) and 42 U.S.C. § 1320d-9.

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 Children and Family 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 either:

(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.

(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.

Renumbered from R.S. 22:213.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1418, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2004, No. 325, § 1, eff. June 18, 2004; Acts 2009, No. 419, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1024. Group, family group, blanket, and association health and accident insurance; mandatory coverage

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 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 limited benefit health insurance policies or contracts authorized to be issued in this state.

Renumbered from R.S. 22:215.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1025. 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. 22:1000 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.

Renumbered from R.S. 22:215.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1025.1. Health insurance policies; mandated offering for treatment of lymphedema

A. Any health insurance policy issued or issued for delivery in this state shall include as an option to be exercised by the policyholder, as defined therein, covered benefits for the treatment of lymphedema, rendered or prescribed by a physician licensed in this state or received in any licensed hospital or in any other public or private facility authorized to provide lymphedema treatment, including multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

B. Any insurer who, on August 1, 2014, has health insurance policies in force in this state shall convert such existing policies to conform to the provisions of this Section on or before the renewal dates.

C. The provisions of this Section shall not apply to limited benefit health insurance policies or contracts authorized to be issued in this state.

Added by Acts 2014, No. 445, § 1.

§ 1026. 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 ensure 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 limited benefit health insurance policies or contracts authorized to be issued in this state.

Renumbered from R.S. 22:215.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 409, § 1. Amended by Acts 1997, No. 1355, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1027. 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 limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:215.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 609, § 1. Amended by Acts 1995, No. 593, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1028. 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 1, 1992. Any policy, contract, or health coverage plan in effect prior to January 1, 1992, shall convert to conform to the provisions of this Subsection on or before the renewal date 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 this 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 limited benefit health insurance policies or contracts authorized to be issued in this state.

Renumbered from R.S. 22:215.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 387, § 1; Acts 1991, No. 994, § 1. Amended by 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; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1029. 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 limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:215.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2005, No. 505, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1030. 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 limited benefit health insurance policies or contracts.

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.

Renumbered from R.S. 22:215.14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 756, § 1. Amended by Acts 1993, No. 185, § 1; Acts

1995, No. 593, § 1; Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2004, No. 431, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1031. 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 mobile screening units. However, benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed six hundred dollars. Services rendered on an outpatient 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 but in no event later than January 1, 1995.

D. The provisions of this Section shall not apply to limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:215.15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 376, § 1. Amended by Acts 1995, No. 593, § 1; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1032. 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 limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:215.16 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 64, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1033. 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.

Renumbered from R.S. 22:215.17 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 637, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003.

§ 1034. 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 issued 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 scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his 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 limited benefit health insurance policies or contracts 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.[1]

Renumbered from R.S. 22:215.21 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 875, § 1. Amended by Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

[1] See, inter alia, 29 U.S.C.A. §§ 1001 et seq., 1021 et seq.

§ 1035. 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 limited benefit and

short-term health insurance policies or contracts.

Renumbered from R.S. 22:215.22 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1013, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1036. 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.

Renumbered from R.S. 22:215.23 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1045, § 1.

§ 1037. 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 registered nurse first assistants 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 limited benefit health

insurance policies or contracts 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" 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.

Renumbered from R.S. 22:215.24 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 190, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1038. 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 Subpart I of Part I 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 R.S. 22:1047 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 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 limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:215.25 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 816, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1039. 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.

Renumbered from R.S. 22:223 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1977, No. 350, § 1.

§ 1040. 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 of this Section, 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 limited benefit health insurance policies or contracts authorized to be issued in this state.

Renumbered from R.S. 22:228.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1125, § 1, eff. Jan. 1, 1998. Amended by Acts 1999, No. 1188, § 1; Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1041. 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.[1]

Renumbered from R.S. 22:229.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1481, § 1.

[1] See, inter alia, 29 U.S.C.A. §§ 1001 et seq., 1021 et seq.

§ 1042. Coverage for rehabilitative services, 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. As an alternative to offering optional coverage, including these benefits as standard benefits in such policies and programs shall be sufficient to comply with the requirements of this Subsection.

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.

Renumbered from R.S. 22:230.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 1071, § 1. Amended by 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; Acts 2008, No. 151, § 1; Acts 2008, No. 529, § 1, eff. June 30, 2008.

§ 1043. 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) Repealed by Acts 2008, No. 648, § 2.

(iv) Panic disorder.

(v) Obsessive-compulsive disorder.

(vi) Major depressive disorder.

(vii) Anorexia/bulimia.

(viii) Repealed by Acts 2008, No. 648, § 2.

(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 health insurance individual policies or contracts; limited benefit health insurance policies or contracts;

and short term health insurance policies or contracts.

(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., medical psychologist licensed under the provisions of R.S. 37:1360.51 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.

Renumbered from R.S. 22:669 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 411, § 1, eff. Jan. 1, 1982. Amended by Acts 1985, No. 213, § 1; Acts 1999, No. 1285, § 1, eff. Jan. 1, 2000; Acts 1999, No. 1309, § 4, eff. Jan. 1, 2000; Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2004, No. 51, § 1; Acts 2009, No. 251, § 5, eff. Jan. 1, 2010; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1044. 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 Subpart I of Part I 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 Subpart B of Part II of Chapter 6 of this Title, a "health insurance issuer" shall include the Office of Group Benefits programs.

(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. 22:999.

(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. 22:999.

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. 22:11, to provide for submission of annual reports by health insurers describing clinical trials for which coverage was provided to insureds, subscribers, or enrollees.

Renumbered from R.S. 22:230.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1357, § 1, eff. July 12, 1999. Amended by Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1045. 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.

Renumbered from R.S. 22:215.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1983, No. 513, § 1. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003.

§ 1046. 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, death or divorce of the employee or member shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves or their eligible dependents who 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 be available under this Section only if the employee or member 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.

D. Continuation shall not be available for any person: (1) who, within thirty-one days of termination, is or could be covered by any other arrangement of hospital, surgical, or medical coverage for individuals in a group; or (2) whose insurance terminated because of fraud; or (3) whose insurance terminated because he failed to pay any required contribution for the insurance; or (4) who is eligible for continuation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA).

E. Repealed by Acts 2012, No. 830, § 2, eff. Jan. 1, 2013.

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 provided by the group policyholder, and pay the first contribution, in advance, to the policyholder or employer no later than the end of the month following the month in which the event that made the employee or member eligible for coverage under this Section occurs. Such form shall be as prescribed in this Section. If the dependent is eligible due to divorce, the event shall be deemed to have occurred on the date of the judgment of divorce.

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 self-insured.

(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.

(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.

Renumbered from R.S. 22:215.13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 343, § 1. Amended by Acts 1993, No. 659, § 1; Acts 2008, No. 199, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2012, No. 830, § 1, eff. Jan. 1, 2013.

§ 1047. 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. 22:245, 999, 1024(B), 1025–1028, 1030–1032, 1034, 1040, and 1042–1044.

(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.

Renumbered from R.S. 22:230.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1133, § 1. Amended by Acts 2003, No. 1115, § 1, eff. July 2, 2003.

§ 1048. 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".

Renumbered from R.S. 22:230.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 799, § 1.

§ 1049. Requirement for coverage of prosthetic devices and prosthetic services

A. Notwithstanding the provisions of R.S. 22:1047 to the contrary, any health coverage plan specified in Subsection H of this Section which is issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after January 1, 2009, shall provide coverage of prosthetic devices and prosthetic services as further provided in this Section.

B. Eligibility and limits of coverage for prosthetic devices and prosthetic services shall be determined by the health coverage plan, based on medical necessity. Any denial or limit of coverage based on lack of medical necessity may be appealed in accordance with R.S. 22:1121 et seq. Such medical necessity determination shall consider information and recommendation from the treating physician in consultation with the insured, including the results of a functional limit test. Such test shall consider but not be limited to the following factors:

(1) The insured's past history, including prior use of prosthetic devices if applicable.

(2) The insured's current condition, including the status of the residual limb and the nature of other medical problems.

(3) The insured's desire to ambulate, with respect to lower limb prosthetic devices, or maximize upper limb function, with respect to upper limb prosthetic devices.

C. A health coverage plan may require prior authorization for prosthetic devices and prosthetic services in the same manner that prior authorization is required for any other covered benefit.

D. A health coverage plan may impose co-payments, deductibles, or coinsurance amounts on prosthetic devices and prosthetic services. The co-payments shall not be greater than the co-payments that apply to other benefits under the plan. The repair and replacement of prosthetic devices also shall be covered subject to co-payments, coinsurance, and deductibles that are no more restrictive than the co-payments, coinsurance, and deductibles that apply to other benefits under the plan, unless necessitated by misuse or loss.

E. A health coverage plan shall include a requirement that prosthetic devices be provided by an accredited facility and a requirement that prosthetic services be prescribed by a licensed physician and provided by an accredited facility.

F. Coverage of prosthetic devices and prosthetic services may be made subject to but no more restrictive than the provisions of a health coverage plan that apply to other benefits under the plan.

G. (1) A health coverage plan may apply an annual limit of benefits payable under this Section of no less than fifty thousand dollars per limb.

(2) This Subsection does not prohibit a health benefit plan from providing coverage that is greater or more favorable to an insured than the requirements of this Subsection.

(3) An insured may choose a prosthetic device that is priced higher than the benefit payable under the health benefit plan and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the provider of the device.

H. As used in the Section:

(1) "Accredited facility" means any entity that is accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC) and that provides prosthetic devices or prosthetic services.

(2) "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 and the Office of Group Benefits programs.

(3) "Prosthetic device" or "prosthesis" means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic device or prosthesis also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

(4) "Prosthetic services" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It shall also include any medically necessary clinical care.

I. The provisions of this Section shall not apply to limited benefit health insurance policies or contracts.

Renumbered from R.S. 22:215.26 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 349, § 1, eff. June 21, 2008. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1050. Requirement for coverage of diagnosis and treatment of autism spectrum disorders in individuals less than twenty-one years of age

A. (1) Except as otherwise provided in Subsection H of this Section, any health coverage plan specified in Paragraph (G)(6) of this Section which is issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after January 1, 2014, shall provide coverage for the diagnosis and treatment of autism spectrum disorders in individuals less than twenty-one years of age.

(2) No insurer or other issuer of a health coverage plan may terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with one of the autism spectrum disorders or has received treatment for an autism spectrum disorder.

B. Coverage under this Section shall not be subject to any limits on the number of visits an individual may make to an autism services provider.

C. Coverage under this Section may be subject to copayment, deductible, and coinsurance provisions of a health coverage plan to the extent that other medical services covered by the plan are subject to these provisions.

D. (1) Coverage under this Section shall be subject to a maximum benefit of thirty-six thousand dollars per year.

(2) Payments made by an insurer or issuer of a health coverage plan on behalf of a covered individual for any care, treatment, intervention, service, or item unrelated to autism spectrum disorders shall not be applied towards the maximum established under this Subsection.

E. This Section shall not be construed as limiting benefits not related to the treatment of autism spectrum disorders that are otherwise available to an individual under a health coverage plan.

F. A health coverage plan may review proposed treatment of autism spectrum disorders according to medical necessity criteria that may be based in part on evidence of continued improvement as a result of the treatment. Medical necessity determinations shall be subject to appeal rights as described in R.S. 22:1121 et seq.

G. As used in this Section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(2) "Autism services provider" means any person, entity, or group which provides treatment of autism spectrum disorders. When the treatment provided by the autism services provider is applied behavior analysis as defined in this Subsection, such provider shall be certified as a behavior analyst by the Behavior Analyst Certification Board or shall provide, if requested, documented evidence of equivalent education, professional training, and supervised experience in applied behavior analysis.

(3) "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has one of the autism spectrum disorders.

(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual.

(6) "Health coverage plan" means 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 and the Office of Group Benefits programs.

(7) "Pharmacy care" means medications prescribed by a licensed physician.

(8) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in this state.

(9) "Psychological care" means direct or consultative services provided by a psychologist licensed in this state.

(10) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists licensed or certified in this state.

(11) "Treatment of autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with one of the autism spectrum disorders by a physician or psychologist who shall be licensed in this state and who shall supervise provision of such care:

(a) Habilitative or rehabilitative care.

(b) Pharmacy care.

(c) Psychiatric care.

(d) Psychological care.

(e) Therapeutic care.

H. The provisions of this Section shall not apply to:

(1) Repealed by Acts 2012, No. 208, § 2.

(2) Individually underwritten, guaranteed renewable health insurance policies.

(3) Limited benefit health insurance policies or contracts.

Added by Acts 2008, No. 648, § 1. Amended by Acts 2009, No. 419, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2012, No. 208, § 1.

Benefits Exceeding Essential Health Benefits—Acts 2012, No. 208

Section 3 of Acts 2012, No. 208 provides:

"Section 3. To the extent that the provisions of this Act require benefits that exceed the essential health benefits specified under Section 1302(b) of the Patient Protection and Affordable Care Act, Public Law No. 111-148, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of a health benefit plan when the plan is offered by a health care insurer in this state."

§ 1051. Benefits for certain services provided by a licensed marriage and family therapist

A. Notwithstanding any contrary provision of a 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, 2009, whenever such plan provides benefits for health-related services that can be lawfully performed by a marriage and family therapist licensed under the provisions of R.S. 37:1101 et seq., the insured or other person entitled to benefits under such health coverage plan shall be entitled to benefits for such services performed by a licensed marriage and family therapist. In order for a policyholder or covered dependent to be eligible for in-network benefits and for a health care provider to be reimbursed directly by a health insurance issuer, such health care provider shall meet a health insurance issuer's contracting and credentialing requirements. Nothing in this Section shall be construed to mean that any health coverage plan is required to include benefits for any additional services.

B. The provisions of this Section shall apply only to those services which a licensed marriage and family therapist is authorized to perform under the provisions of R.S. 37:1101 et seq.

C. As used in this Section, "health coverage plan" means 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.

Added by Acts 2008, No. 305, § 1.

§ 1052. Exemption from health insurance mandates

Notwithstanding any other provision of this Title to the contrary and not unless otherwise specifically provided in an act of the legislature, the provisions of this Subpart shall not apply to limited benefit health insurance policies or contracts, as defined by R.S. 22:47(2)(c).

Added by Acts 2010, No. 549, § 1.

§ 1053. Requirement for coverage of step therapy or fail first protocols

A. Notwithstanding the provisions of R.S. 22:1047 to the contrary, any health care coverage plan specified in Subsection D of this Section which includes prescription benefits as part of its policy or contract, which utilizes step therapy or fail first protocols, and which is issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after January 1, 2011, shall comply with the provisions of this Section.

B. When medications for the treatment of any medical condition are restricted for use by an insurer by a step therapy or fail first protocol, the prescribing physician shall have access to a clear and convenient process to expeditiously request an override of such restriction from the insurer. An override of such restriction shall be expeditiously granted by the insurer under any of the following circumstances:

(1) The prescribing physician can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the insured's disease or medical condition.

(2) The prescribing physician can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured and known characteristics of the drug regimen.

(3) The prescribing physician can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

C. The duration of any step therapy or fail first protocol shall not be longer than the customary period for the medication when such treatment is demonstrated by the prescribing physician to be clinically ineffective. When the health coverage plan can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than the customary period for such medication to provide any relief or an amelioration to the insured, the step therapy or fail first protocol may be extended for an additional period of time no longer than the original customary period for the medication.

D. As used in this Section, a "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 and the Office of Group Benefits programs.

Added by Acts 2010, No. 884, § 1. Amended by Acts 2011, No. 144, § 1.

§ 1054. Requirement for access to coverage for individuals diagnosed with a

terminal condition

A. Notwithstanding any other provision of the law to the contrary and particularly the provisions of R.S. 22:1047, no health care coverage plan shall deny coverage for medically necessary treatment prescribed by a physician and agreed to by a fully informed insured or, if the insured lacks legal capacity to consent, by a person who has legal authority to consent on the insured's behalf, based solely on an insured's life expectancy or the fact that the insured is diagnosed with a terminal condition.

B. Refusing coverage for medically necessary treatment to be rendered to an insured based solely on the insured's life expectancy or the fact that the insured is diagnosed with a terminal condition shall be a violation of this Section.

C. (1) As used in this Section, "terminal condition" means any malignancy or chronic end-stage cardiovascular or cerebral vascular disease that is likely to result in the insured's death.

(2) As used in this Section, "health coverage plan" means any hospital, health or medical 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 and the Office of Group Benefits programs.

Added by Acts 2014, No. 541, § 1, eff. June 5, 2014.

SUBPART B-1. COVERAGE OF PRESCRIPTION DRUGS THROUGH A DRUG FORMULARY

§ 1060.1. Definitions

As used in this Subpart, the following definitions shall apply:

(1) "Authorized prescriber" means a person licensed, registered, or otherwise authorized by the appropriate licensing board to prescribe prescription drugs in the course of professional practice.

(2) "Drug formulary" or "formulary" means a list of prescription drugs which meets any of the following criteria:

(a) For which a health benefit plan provides coverage.

(b) For which a health benefit plan approves payment.

(c) That a health insurance issuer encourages or offers incentives for physicians or other authorized prescribers to prescribe.

(3) "Enrollee" or "insured" means an individual who is enrolled or insured by a health insurance issuer under a health benefit plan.

(4) "Health benefit plan" or "plan" means an entity which provides benefits through or by a health insurance issuer 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; however, "health benefit plan" shall not include benefits due under Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950[1] 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, benefits for long-term care, nursing home care, home health care, or specific diseases or illnesses, or any other limited benefit policy or contract as defined in R.S. 22:47(2)(c).

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

(6) "Health insurance issuer" or "issuer" means any entity that offers a health benefit plan through a policy, contract, or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Subpart, a "health insurance issuer" or "issuer" shall include but not be limited to a health maintenance organization as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title[2]. 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[3] or the Office of Group Benefits.

(7) "Physician" means a person licensed by the Louisiana State Board of Medical Examiners.

(8) "Prescription drug" or "drug" means any of the following:

(a) A substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public.

(b) A drug or device that under federal law is required, before being dispensed or delivered, to be labeled with the statement: "Caution: Federal law prohibits dispensing without prescription" or "Rx only" or another legend that complies with federal law.

(c) A drug or device that is required by federal or state statute or regulation to be dispensed on prescriptions or that is restricted to use by a physician or other authorized prescriber.

Added by Acts 2011, No. 350, § 1, eff. Jan. 1, 2012.

[1] R.S. 23:1020 et seq.

[2] R.S. 22:241 et seq.

[3] 29 U.S.C.A. § 1001 et seq.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which added this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or

renewed on or after January 1, 2012."

§ 1060.2. Notice and disclosure of certain information required

A health insurance issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) Provide in plain language in the coverage documentation provided to each enrollee each of the following:

(a) Notice that the plan uses one or more drug formularies.

(b) An explanation of what a drug formulary is.

(c) A statement regarding the method the health insurance issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary.

(d) A statement of how often the health insurance issuer reviews the contents of each drug formulary.

(e) Notice, on a form approved by the Department of Insurance, that an enrollee may contact the health insurance issuer to determine whether a specific drug is included in a particular drug formulary.

(2) Disclose to an individual upon request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary.

(3) Notify an enrollee and any other individual who requests information pursuant to this Section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness.

Added by Acts 2011, No. 350, § 1, eff. Jan. 1, 2012.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which added this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012."

§ 1060.3. Continuation of coverage required; other drugs not precluded

A. A health insurance issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or medical illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. Nothing herein shall prohibit the health insurance issuer from providing information to the enrollee regarding alternative covered drugs.

B. This Section shall not prohibit a physician or other authorized prescriber from prescribing a drug that is an alternative to a drug for which continuation of coverage is required by Subsection A of this Section if the alternative drug meets each of the following conditions:

(1) The drug is covered under the health benefit plan.

(2) The drug is medically appropriate for the enrollee.

Added by Acts 2011, No. 350, § 1, eff. Jan. 1, 2012. Amended by Acts 2012, No. 316, § 1, eff. May 25, 2012.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which added this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012."

§ 1060.4. Adverse determination

A. The refusal of a health insurance issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for the purposes of Subpart F of this Part, R.S. 22:1121 et seq., relative to medical necessity review organizations, if each of the following conditions is met:

(1) The drug is not included in a drug formulary used by the health benefit plan.

(2) The enrollee's physician or other authorized prescriber has determined the drug is medically necessary.

B. The enrollee may appeal the adverse determination pursuant to Subpart F of this Part, R.S. 22:1121 et seq., relative to medical necessity review organizations.

Added by Acts 2011, No. 350, § 1, eff. Jan. 1, 2012.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which added this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012."

§ 1060.5. Specialty drug tiers; prohibitions; limits on copayments

A. A health insurance issuer of a health benefit plan that covers prescription drugs, as defined in R.S. 22:1060.1(8), and utilizes a formulary tier that is higher than a preferred or non-preferred brand drug tier, sometimes known as a specialty drug tier, shall limit any required copayment or coinsurance applicable to drugs on such tier to an amount not to exceed one hundred and fifty dollars per month for each drug up to a thirty-day supply of any single drug. This limit

shall be inclusive of any copayment or coinsurance. This limit shall be applicable after any deductible is reached and until the individual's maximum out-of-pocket limit has been reached.

B. A health care issuer of a health benefit plan that covers prescription drugs, as defined in R.S. 22:1060.1(8), and utilizes specialty tiers shall be required to implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a non-formulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and shall be subject to the health plan internal review process and the state external review process.

C. The provisions of this Section shall not apply to the Office of Group Benefits or to the claims of the Office of Group Benefits enrollees administered by health insurance issuers.

Added by Acts 2014, No. 453, § 1, eff. Jan. 1, 2015.

SUBPART C. ASSURING PORTABILITY, AVAILABILITY, RENEWABILITY OF HEALTH INSURANCE COVERAGE

§ 1061. Definitions

As used in R.S. 22:984 and 1061 through 1079, 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) of this Paragraph 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. 22:1062(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 Subpart I of Part I of Chapter 2 of this Title unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.[1] 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.

(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 specified in reasonable regulations issued by the commissioner of insurance.

(c) Benefits not subject to requirements if offered as independent,

non-coordinated 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 supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.

(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)(i) A health benefit plan provided to members of the Peace Corps.

(ii) Such term does not include coverage consisting solely of coverage of excepted benefits, as defined in Paragraph (3) of this Section.

(k) Medical assistance coverage provided under 42 USCA 1397 et seq.

(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. 22:1046.

(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, convention, or association of churches. A plan established and maintained for its employees or their beneficiaries by a church, 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, convention, or association of churches, if such organization is controlled by or associated with a church, 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, 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. 22:1063(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. 22:1062(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) of this Subparagraph.

(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.

(y) "Modification affecting drug coverage" means any of the following:

(i) Removing a drug from a formulary.

(ii) Adding a requirement that an enrollee receive prior authorization for a drug.

(iii) Imposing or altering a quantity limit for a drug.

(iv) Imposing a step-therapy restriction for a drug.

(v) Moving a drug to a higher cost-sharing tier, unless a generic alternative is available.

Renumbered from R.S. 22:250.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 30, § 1; Acts 2010, No. 123, § 1, eff. June 8, 2010; Acts 2010, No. 919,

§ 1, eff. Jan. 1, 2011; Acts 2011, No. 350, § 1, eff. Jan. 1, 2012.

[1] See, inter alia, 29 U.S.C.A. §§ 1001 et seq., 1021 et seq.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which added subpar. (5)(y) of this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012."

§ 1062. 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. 22:1061(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 Subsection 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) Subject to eligibility requirements of group coverage pursuant to state law, 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 child was enrolled in the Louisiana Children's Health Insurance Program or a Medicaid program prior to requesting enrollment in the group health plan, but is no longer eligible to be covered under either the Louisiana Children's Health Insurance Program or a Medicaid 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 child losing eligibility for coverage by the Louisiana Children's Health Insurance Program or a Medicaid 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 or a Medicaid 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 or a Medicaid 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.

Renumbered from R.S. 22:250.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 2004, No. 269, § 1, eff. June 15, 2004; Acts 2005, No. 47, § 1, eff. June 16, 2005; Acts 2006, No. 348, § 1, eff. June 13, 2006; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1062.1. Special enrollment period

A. Every group health plan issued by a health insurer or a health maintenance organization shall provide for a special enrollment period for employees or dependents if either of the following apply:

(1) The employee or dependent loses eligibility for Medicaid or coverage under the Louisiana Children's Health Insurance Program and the employee requests, not later than sixty days after the date of termination of such coverage, coverage

under a group health plan for which the employee or dependent is eligible.

(2) The employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or the Louisiana Children's Health Insurance Program and the employee requests, not later than sixty days after the date of determination of eligibility, coverage under a group health plan for which the employee or dependent is eligible. In the event of such eligibility, the Department of Health and Hospitals shall ensure that each eligible enrollee, or, in the case of an enrollee in the Louisiana Children's Health Insurance Program, the child's parent or guardian, receives information regarding the special enrollment period. The department shall provide consistent communication and facilitation for everyone eligible to enroll in a group health plan during the special enrollment period.

B. The Department of Insurance may promulgate rules and regulations, pursuant to the Administrative Procedure Act, as necessary to assure compliance with the provisions of this Section and Section 311 of the Children's Health Insurance Program Reauthorization Act of 2009.[1]

Added by Acts 2009, No. 243, § 1, eff. Aug. 15, 2009.

[1] See P.L. 111-3.

§ 1063. 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. 22:1062, 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.

C. A health insurance issuer offering group health insurance coverage shall not rescind such coverage with respect to an enrollee or insured once the enrollee or insured is covered under such coverage involved, except that this Subsection shall not apply to an enrollee or insured who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact. Such coverage may not be cancelled except with prior notice to the enrollee or insured, and only as permitted by federal law or regulation pursuant to 42 U.S.C.A. Section 300gg-12, (Public Health Services Act). The provisions of this Subsection shall not apply to limited benefit health insurance policies or contracts, disability income, long-term care, nursing home care, home health care, community based care, dental or vision benefits, Medicare supplement, specified disease or illness, hospital indemnity or other fixed indemnity insurance, workers' compensation or similar insurance.

Renumbered from R.S. 22:250.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 2010, No. 484, § 1, eff. Sept. 23, 2010.

§ 1064. Certification of coverage

The provisions of R.S. 22:1062(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.

Renumbered from R.S. 22:250.14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997.

§ 1065. 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 Subpart.

(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.

(4) 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.

Renumbered from R.S. 22:250.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 2004, No. 269, § 1, eff. June 15, 2004.

§ 1066. 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) of this Paragraph 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) of this Paragraph 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 of this Section, 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.

Renumbered from R.S. 22:250.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 30, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1067. 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. 22:1061(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. 22:1063 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. 22:1061(5)(b).

Renumbered from R.S. 22:250.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997.

§ 1068. 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. Such health insurance coverage may not be cancelled except with prior notice to the enrollee or insured, and only as permitted by federal law or regulation pursuant to 42 U.S.C. A. Section 300gg-12, (Public Health Services Act). The provisions of this Paragraph shall not apply to limited benefit health insurance policies or contracts authorized to be issued in this state. The provisions of this Subsection shall not apply to limited benefit health insurance policies or contracts, disability income, long-term care, nursing home care, home health care, community based care, dental or vision benefits, Medicare supplement, specified disease or illness, hospital indemnity or other fixed indemnity insurance, workers' compensation or similar insurance.

(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. 22:1067(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. 22:1067(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 with the commissioner of insurance the notice and the insurance product being discontinued for certification that the notice is in compliance with this Section. Notice shall not be issued to the insureds or enrollees until the expiration of twenty days after the notice and insurance product being discontinued have been filed unless the commissioner of insurance gives his written approval prior to that time.

(b) In the case of a discontinuation in the small group market or large group market under Subparagraph (a) of this Paragraph, any plan sponsor's policy or coverage that is not subject to renewal during the minimum one-hundred-eighty-day notice period shall remain in force until the termination date upon which the contracted period of coverage ends. Any plan sponsor's policy or coverage whose renewal date falls within the minimum one-hundred-eighty-day notice period shall remain in force for one hundred eighty days from the date that the notice of discontinuation was issued.

(c) 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. A health insurance issuer may modify health insurance coverage offered to a group health plan if each of the following conditions is met:

(1) The modification occurs at the time of coverage renewal.

(2) The modification is approved by the commissioner and is effective on a uniform basis among all small or large employers covered by that group health plan. However, for purposes of this Section, modifications affecting drug coverage shall not require approval by the commissioner.

(3) The issuer notifies, on a form approved by the Department of Insurance, each affected covered small or large employer and enrollee of the modification, including modification of coverage of a particular product or modification of drug coverage, not later than the sixtieth day before the date the modification is effective.

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.

Renumbered from R.S. 22:250.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 127, § 1, eff. June 9, 1999; Acts 2010, No. 484, § 1, eff. Sept. 23, 2010; Acts 2010, No. 595, § 1; Acts 2011, No. 350, § 1, eff. Jan. 1, 2012; Acts 2012, No. 316, § 1, eff. May 25, 2012.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which amended subsec. D of this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012."

§ 1069. 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.

Renumbered from R.S. 22:250.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997.

§ 1070. Exclusion of certain plans

A. The requirements of this Subpart 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 Subpart 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 Subpart 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 Subpart 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 Subpart prior to January 1, 1999.

C. The requirements of this Subpart 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. 22:1061(3)(a).

D. (1) The requirements of this Subpart 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. 22:1061(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 Subpart 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. 22:1061(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 Subpart 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. 22:1061(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) 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.

Renumbered from R.S. 22:250.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 29, § 1.

§ 1071. 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 Subpart with respect to such issuers.

B. The commissioner of insurance shall enforce the provisions of this Subpart 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 Subpart, 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 Subpart 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 Chapter 12 of this Title, R.S. 22:2191 et seq.

D. (1) Penalties collected for enforcement of this Subpart 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 Subpart 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 Subpart 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 Louisiana 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 Subpart. In determining the cost of administering and enforcing the provisions of this Subpart, 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 Subpart.

Renumbered from R.S. 22:250.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 445, § 1, eff. June 18, 1999; Acts 2001, No. 63, § 1, eff. May 24, 2001; Acts 2009, No. 317, § 1; Acts 2013, No. 220, § 7, eff. June 11, 2013.

§ 1072. 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 health insurance policies and short-term policies or contracts 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. 22:1075(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.

Renumbered from R.S. 22:250.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 445, § 1, eff. June 18, 1999; Acts 2001, No. 133, § 1, eff. May 25, 2001; Acts 2004, No. 269, § 1, eff. June 15, 2004; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1073. 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. 22:1061(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. 22:1061(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. 22:1068(B)(1) or (2), relating to nonpayment of premiums or fraud.

(4) Who, if offered the option of continuation of coverage under a COBRA continuation provision or under a similar state program, elected this coverage.

(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 Subpart 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. 22:1074(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. 22:1074(B)(1) or (2) relating to nonpayment of premiums or fraud.

Renumbered from R.S. 22:250.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997; Acts 2001, No. 174, § 1,

eff. May 31, 2001. Amended by Acts 2010, No. 123, § 1, eff. June 8, 2010.

§ 1074. 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. Such health insurance coverage may not be cancelled except with prior notice to the enrollee or insured, and only as permitted by federal law or regulation pursuant to 42 U.S.C.A. Section 300gg-12, (Public Health Services Act). The provisions of this Paragraph shall not apply to limited benefit health insurance policies or contracts authorized to be issued in this state. The provisions of this Subsection shall not apply to limited benefit health insurance policies or contracts, disability income, long-term care, nursing home care, home health care, community based care, dental or vision benefits, Medicare supplement, specified disease or illness, hospital indemnity or other fixed indemnity insurance, workers' compensation or similar insurance.

(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 with the commissioner of insurance the notice and the insurance product being discontinued for certification that the notice is in compliance with this Section. Notice shall not be issued to the insureds or enrollees until the expiration of twenty days after the notice and insurance product being discontinued have been filed unless the commissioner of insurance gives his written approval prior to that time.

(b) In the case of a discontinuation in the individual market under Subparagraph (a) of this Paragraph, any individual's policy or coverage that is not subject to renewal during the minimum one-hundred-eighty-day notice period shall remain in force until the termination date upon which the contracted period of coverage ends. Any individual's policy or coverage whose renewal date falls within the minimum one-hundred-eighty-day notice period shall remain in force for one hundred eighty days from the date that the notice of discontinuation was issued.

(c) 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. A health insurance issuer may modify the health insurance coverage for a

policy form offered to individuals in the individual market if each of the following conditions is met:

(1) The modification occurs at the time of coverage renewal.

(2) The modification is approved by the commissioner, is consistent with state law, and is effective on a uniform basis among all the individuals with that policy form. However, for purposes of this Section, modifications affecting drug coverage shall not require approval by the commissioner.

(3) The issuer notifies, on a form approved by the Department of Insurance, each affected individual of the modification, including modification of coverage of a particular product or modification of drug coverage, not later than the sixtieth day before the date the modification is effective.

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.

Renumbered from R.S. 22:250.13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 1999, No. 127, § 1, eff. June 9, 1999; Acts 2010, No. 484, § 1, eff. Sept. 23, 2010; Acts 2010, No. 595, § 1; Acts 2011, No. 350, § 1, eff. Jan. 1, 2012; Acts 2012, No. 316, § 1, eff. May 25, 2012.

Application—Acts 2011, No. 350

Section 2 of Acts 2011, No. 350 (§ 1 of which amended subsec. D of this section) provides:

"Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012."

§ 1075. Standards relating to benefits for mothers and newborns

A. (1) The provisions of R.S. 22:1065(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 Subpart.

(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.

Renumbered from R.S. 22:250.15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997. Amended by Acts 2004, No. 269, § 1, eff. June 15, 2004.

§ 1076. General exceptions

A. The requirements of this Subpart shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in R.S. 22:1061(3)(a).

B. The requirements of this Subpart shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in R.S. 22:1061(3)(b), (c), or (d) if the benefits are provided under a separate policy, certificate, or contract of insurance.

Renumbered from R.S. 22:250.16 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1138, § 1, eff. July 14, 1997.

§ 1077. 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 in one of the following ways, whichever is earlier:

(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.

(3) Not later than January 1, 2000.

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 do either of the following:

(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.

(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.

Renumbered from R.S. 22:250.17 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 30, § 2. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011.

§ 1078. 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. 15:1503 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.

Renumbered from R.S. 22:250.19 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1185, § 1. Amended by Acts 2010, No. 861, § 9.

§ 1079. 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.

Renumbered from R.S. 22:250.20 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 659, § 1.

§ 1080. Third-party premium payments; refusal of acceptance

A. No health insurance issuer or health maintenance organization shall refuse the receipt of a premium payment when such payment is made by a third party to the insurance contract, provided that the payment is made from or pursuant to a fund or grant established by any one of the following:

(1) The Ryan White HIV/AIDS Program pursuant to Title XXVI of the Public Health Service Act.

(2) Indian tribes, tribal organizations, or urban Indian organizations.

(3) State or federal government programs.

(4) The American Kidney Fund.

B. This Section shall not be construed to require a health insurance issuer or health maintenance organization to accept a third-party premium payment from a health care provider.

Added by Acts 2014, No. 491, § 1.

SUBPART D. RATE REVIEW

Change of Heading—Acts 2014, No. 718

Acts 2014, No. 718, § 1 changed the Subpart D heading from "Rates" to "Rate Review".

§ 1091. Health insurance plans subject to rate review

A. The provisions of this Subpart shall apply to any health benefit plan which provides coverage in the small group market or individual market, including any policy or subscriber agreement covering residents of this state. The provisions of this Section shall apply regardless of where such policy or subscriber agreement was issued or issued for delivery in this state and shall include any employer, association, or trustee of a fund established by an employer, association, or trust for multiple associations who shall be deemed the policyholder, covering one or more employees of such employer, one or more members or employees of members of such association or multiple associations, for the benefit of persons other than the employer, the association, or the multiple associations, as well as their officers or trustees. The provisions of this Subpart shall not apply to the following, unless specifically provided for:

(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.

(3) Excepted benefit or limited benefits as defined in this Title.

B. As used in this Subpart, the following terms shall have the meanings ascribed to them in this Section:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries that a health insurance issuer is in compliance with the provisions of this Subpart, based upon the actuary's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the health insurance issuer in establishing rates for applicable health benefit plans.

(2) "Excessive" means the rate charged for the health insurance coverage causes the premium or premiums charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the particular product. In determining whether the rate is unreasonably high in relation to the benefits provided, the department shall consider each of the following:

(a) Whether the rate results in a projected medical loss ratio below the federal medical loss ratio standard in the applicable market to which the rate applies, after accounting for any adjustments allowable under federal law.

(b) Whether one or more of the assumptions on which the rate is based is not supported by substantial evidence.

(c) Whether the choice of assumptions or combination of assumptions on which the rate is based is unreasonable.

(3) "Federal review threshold" means any rate increase that results in a ten percent or greater rate increase, or such other threshold as required by federal law or regulation or any rate that, when combined with all rate increases and decreases during the previous twelve-month period, would result in an aggregate ten percent or greater rate increase. For reporting purposes, the federal threshold shall mean any rate increase above zero percent or such other threshold

as required by federal law or regulation.

(4) "Grandfathered health plan coverage" has the same meaning as that in 45 C.F.R. 147.140 or other subsequently adopted federal law, rule, regulation, directive, or guidance.

(5) "Health benefit plan", "plan", "benefit", or "health insurance coverage" means services 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, excepted benefits as defined in R.S. 22:1061(3)(a) are not included as a "health benefit plan".

(6) "Health insurance issuer" means any entity that offers health insurance coverage through a policy, certificate of insurance, or subscriber agreement subject to state law that regulates the business of insurance. A "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title.

(7) "Health savings accounts" means those accounts for medical expenses authorized by 26 U.S.C. § 220 et seq.

(8) "Inadequate" means rates for a particular product are clearly insufficient to sustain projected losses and expenses, or the use of such rates.

(9) "Index rate" means the average rate resulting from the estimated combined claims experience for all Essential Health Benefits, pursuant to 42 U.S.C. § 18022, Section 1302(b) of the Patient Protection and Affordable Care Act, of all nontransitional and nongrandfathered health plan coverage within a health insurance issuer's single, statewide risk pool in the individual market and within a health insurance issuer's single, statewide risk pool in the small group market, with a separate index rate being calculated for each market. Health insurance issuers may make any market-wide and plan- or product-specific adjustments to an index rate as permitted or as required by federal law, rules, or regulations.

(10) "Individual health insurance coverage" or "individual policy" means health insurance coverage offered to individuals in the individual market or through an association.

(11) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(12) "Insured" includes any policyholder, including a dependent, enrollee, subscriber, or member, who is covered through any policy or subscriber agreement offered by a health insurance issuer.

(13) "Large group" or "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, and beginning on January 1, 2016, an employer who employed an average of

at least one hundred 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.

(14) "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.

(15) "Medical loss ratio" means the ratio of expected incurred benefits to expected earned premium over the time period of coverage, subject to the requirements of federal law, regulation, or rule.

(16) "New rate filing" means a rate filing for any particular product which has not been issued or delivered in this state.

(17) "Particular product" means a basic insurance policy form, certificate, or subscriber agreement delineating the terms, provisions, and conditions of a specific type of coverage or benefit under a particular type of contract with a discrete set of rating and pricing methodologies that a health insurance issuer offers in the state.

(18) "Rate" means the rate initially filed or filed as a result of determination of rates by a health insurance issuer for a particular product.

(19) "Rate change" means the rates for any health insurance issuer for a particular product differ from the rates on file with the department, including but not limited to any change in any current rating factor, periodic recalculation of experience, change in rate calculation methodology, change in benefits, or change in the trend or other rating assumptions.

(20) "Rate increase" means any increase of the rates for a particular product. When referring to federal review thresholds, "rate increase" includes a premium volume-weighted average increase for all insureds for the aggregate rate changes during the twelve-month period preceding the proposed rate increase effective date.

(21) "Rating period" means the calendar period for which rates established by a health insurance issuer are in effect.

(22) "Small group" or "small employer" means any person, firm, corporation, partnership, trust, or association actively engaged in business which has employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year, and beginning on January 1, 2016, an employer who employed an average of at least one but not more than one hundred employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. "Small group" or "small employer" shall include coverage sold to small groups or small employers through associations or through a blanket policy. For purposes of rate calculation by a health insurance issuer, a small employer group consisting of one employee shall be rated within a health insurance issuer's individual market risk pool, unless that health insurance issuer provides only employer coverage and thus has only a small group market risk pool.

(23) "Unfairly discriminatory" means rates that result in premium differences between insureds within similar risk categories that do not reasonably correspond to differences in expected costs. When applied to rates charged, "unfairly discriminatory" shall refer to any rate charged by small group or individual health insurance issuers in violation of R.S. 22:1095.

(24) "Unjustified" means a rate for which a health insurance issuer has provided data or documentation to the department in connection with rates for a particular product that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of the rate may be determined or is otherwise inadequate insofar as the rate charged is clearly insufficient to sustain projected losses and expenses.

(25) "Unreasonable" means any rate that contains a provision or provisions that are any of the following:

(a) Excessive.

(b) Unfairly discriminatory.

(c) Unjustified.

(d) Otherwise not in compliance with the provisions of this Title, or with other provisions of law.

Renumbered from R.S. 22:228.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 777, § 2, eff. Sept. 30, 1992. Amended by Acts 1993, No. 54, § 1; Acts 2001, No. 272, § 1, eff. Jan. 1, 2002; Acts 2003, No. 659, § 1; Acts 2004, No. 663, § 1; Acts 2009, No. 93, § 1; Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1092. Health insurance issuers; rate filings and rate increases

A. Every health insurance issuer shall file with the department every proposed rate to be used in connection with all of its particular products. Every such filing shall clearly state the date of the filing, the proposed rate, and the effective date of the proposed rate. All rate filings required by this Subpart shall be made in accordance with the following:

(1) Rate filings shall be made within the time prescribed by the department.

(2) All health insurance issuers assuming, merging, or acquiring blocks of business shall be considered as proposing new rates.

(3) The commissioner may set the date upon which index rates in a market are not subject to revision by an issuer.

B. All proposed rate filings shall be filed in the manner and form prescribed by the department.

C. When a rate filing made pursuant to this Subpart is not accompanied by the information upon which the health insurance issuer supports the rate filing, with the result that the department does not have sufficient information to determine whether the rate filing meets the requirements of this Subpart, the department

may require the health insurance issuer to refile the information upon which it supports its filing. The time period provided in this Section shall begin anew and commence as of the date the proper information is furnished to the department.

D. All proposed rate filings may be reviewed for compliance with R.S.22:1095 and with other provisions of law governing rates in the individual market and the small group market. A review of rates made pursuant to this Subpart shall not constitute a determination under the Administrative Procedure Act, R.S. 49:950 et seq., nor shall such a review of rates be subject to other administrative or judicial relief.

E. Each rate filing shall be reviewed by the department to determine whether such filing is reasonable and compliant with this Subpart.

F. The department shall consider the following criteria to determine whether a rate is unreasonable:

(1) Whether the rate is excessive.

(2) Whether the rate is unfairly discriminatory.

(3) Whether the rate is unjustified.

(4) Whether the rate does not otherwise comply with the provisions of this Title or with other provisions of law.

G. The review of any proposed rate may take into consideration the following nonexhaustive list of factors and any other factors established by federal rule or regulation to the extent applicable, to determine whether the filing under review is unreasonable:

(1) The impact of medical trend changes by major service categories.

(2) The impact of utilization changes by major service categories.

(3) The impact of cost-sharing changes by major service categories.

(4) The impact of benefit changes.

(5) The impact of changes in an insured's risk profile.

(6) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase, if applicable.

(7) The impact of changes in reserve needs.

(8) The impact of changes in administrative costs related to programs that improve health care quality.

(9) The impact of changes in other administrative costs.

(10) The impact of changes in applicable taxes or licensing or regulatory fees.

(11) Medical loss ratio.

(12) The financial performance of the health insurance issuer, including capital and surplus levels.

H. Within fifteen days of submission of any proposed rate increase that meets or exceeds the federal review threshold, the department shall publish on its website any documents or forms as required by federal law, rule, or regulation to maintain an effective rate review program. After publication, the public shall have thirty days to submit comments.

I. For any rate increase that meets or exceeds the federal review threshold, the department shall post a notice of final determination on its website and undertake any other actions necessary pursuant to Section 2794 of the Public Health Service Act.

Renumbered from R.S. 22:228.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 777, § 2, eff. Sept. 30, 1992. Amended by Acts 2001, No. 272, § 1, eff. Jan. 1, 2002; Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1092.1. Grandfathered health coverage; rating practices

The rating practices and rating methods and the rating restrictions imposed by law upon grandfathered health coverage in the individual market and small group market that are in effect on the day that this Section takes effect, including the restrictions on rate increases and required notices for such increases, shall remain binding upon such grandfathered health coverage. Such grandfathered coverage is exempt from the provisions of this Subpart, unless specifically provided for otherwise.

Added by Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1093. Disclosure of rating practices and renewability provisions for insureds

A. Each health insurance issuer shall make reasonable disclosure in solicitation and sales materials provided to insureds of the provisions relating to renewability of coverage.

B. Each health insurance issuer shall provide its insureds with a written notice and reasonable explanation and justification, including the contributing factors for the rate increase, for any rate increase no less than forty-five days prior to the effective date of such increase.

Renumbered from R.S. 22:228.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 777, § 2, eff. Sept. 30, 1992. Amended by Acts 2001, No. 272, § 1, eff. Jan. 1, 2002; Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1094. Maintenance of records for the department

A. Each health insurance issuer shall maintain at its principal place of business a complete and detailed description of its rating 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 and the rules and regulations of the department.

B. Each health insurance issuer shall file once per calendar year with the department an actuarial certification that the health insurance issuer is in compliance with this Subpart and that the rating methods of the health insurance issuer are actuarially sound. A copy of such certification shall be retained by the health insurance issuer at its principal place of business.

C. A health insurance issuer shall make the information and documentation described in Subsection A of this Section available to the department for inspection.

Renumbered from R.S. 22:228.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 777, § 2, eff. Sept. 30, 1992. Amended by Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1095. Rating factors; risk pools; individual market plan and calendar year requirement

A. Health insurance issuers may vary premiums from the plan-adjusted index rate in the individual or small group market due only to one or more of the following factors:

(1) The number of persons such product or coverage covers, whether an individual or family.

(2) Geographic rating area, as established in accordance with this Section.

(3) Age, except that such variation shall be no more than three-to-one for adults.

(4) Tobacco use as defined in 45 C.F.R. 147.102 or any subsequent federal law, except that such rate shall not vary by more than one- and one-half-to-one.

B. Every health insurance issuer in this state shall maintain a single, separate, and distinct risk pool for the individual market and a single, separate, and distinct risk pool for the small group market. Health insurance issuers of student health plans shall maintain a single, separate, and distinct risk pool for student health plans.

C. To the extent that they are applied to coverage issued to members within a family under a small group plan, the ratings variations permitted under Paragraphs (A)(3) and (4) of this Section shall be attributed to each member to whom those factors apply and the factors may be applied only as permitted by federal law.

D. Consistent with the single risk pool requirement, as of January 1, 2015, all nongrandfathered coverage in the individual market shall be offered on a calendar year basis. For purposes of new enrollment effective on any date other than January first, the first policy year following such enrollment may comprise a prorated policy year, ending on December thirty-first. Any exceptions or modifications to the calendar year requirement by federal law or rule shall also apply to health insurance issuers under this Section.

E. The department shall determine the geographic rating area or areas in this state by rule, regulation, bulletin, or any other mechanism made available by law.

F. Any rate proposed to be used by a health insurance issuer shall be submitted and controlled by this Subpart. However, the commissioner shall have the authority to grant transitional relief from the provisions of this Subpart.

Renumbered from R.S. 22:228.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 655, § 1. Amended by Acts 1995, No. 593, § 1; Acts 1995, No. 1173, § 1; Acts 1997, No. 1165, § 1; Acts 2001, No. 272, § 1, eff. Jan. 1, 2002; Acts 2004, No. 426, § 1; Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1096. Regulations; preemption

A. The commissioner may promulgate such rules and regulations as may be necessary and proper to carry out the provisions of this Subpart and Section 2794 of the Public Health Service Act. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

B. If at any time a provision of this Subpart is in conflict with federal law or with regulations promulgated pursuant to federal law, such provision shall be preempted only to the extent necessary to avoid direct conflict with federal law or regulations. The commissioner shall subsequently administer and enforce the provisions of this Subpart in a manner that conforms to federal law or regulations. If necessary to preserve the department's regulatory authority or if necessary to effectively enforce the provisions of this Subpart, the commissioner may promulgate rules or regulations to that effect and may issue directives or bulletins on a provisional basis before such rules or regulations take effect. Such provisional basis for the issuance of directives or bulletins under this Section shall not exceed a period of one year.

Renumbered from R.S. 22:229 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 636, § 1. Amended by Acts 1991, No. 848, § 1; Acts 1993, No. 297, § 1; Acts 1995, No. 418, § 1; Acts 2010, No. 595, § 1; Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1097. 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. As used in this Section, "severe disability" 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, 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 any developmental disability, including but not limited to autism, cerebral palsy, epilepsy, intellectual disabilities, and other neurological impairments.

C. No insurance company shall charge unfair discriminatory premiums, policy fees, or rates for, or refuse to provide any policy, subscriber agreement, 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 or 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, as may be permitted by federal law.

Renumbered from R.S. 22:652.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 766, § 1. Amended by Acts 1982, No. 643, § 1; Acts 2014, No. 718, § 1, eff. June 18, 2014; Acts 2014, No. 811, § 11, eff. June 23, 2014.

§ 1098. Frequency of rate increases; limitations

A. The following rate increase limitations shall apply to all health benefit plans, limited benefits, and excepted benefits:

(1) Health insurance issuers of limited benefits and excepted benefits policies shall not increase rates during the initial twelve months of coverage, and may not do so more than once in any six-month period following the initial twelve-month period.

(2) Health insurance issuers shall not increase rates for policies or plans in the individual market during the plan year. Rate increases for policies or plans in the individual market may occur only upon renewal or upon commencement of the policy or plan year.

(3) Rates for policies or plans in the small group market shall not increase during the initial twelve months of coverage.

B. No health insurance issuer issuing policies or subscriber agreements shall increase its rates or reduce the covered benefits under the policy or subscriber agreement after the commencement of the minimum one-hundred-eighty-day period following the notice of the discontinuation of offering all health insurance coverage as described in R.S. 22:1068(C)(2)(a)(i) or 1074(C)(2)(a)(i).

C. This Section shall not affect increases in the premium amount due to any change required for compliance with the addition of a newly covered person or policy benefit level, or such changes necessary to comply with R.S. 22:1095 or other state or federal law, regulation, or rule.

Added by Acts 2014, No. 718, § 1, eff. June 18, 2014.

§ 1099. Enforcement

A. Whenever the commissioner has reason to believe that any health insurance

issuer is not in compliance with any of the provisions of this Subpart, he shall notify such health insurance issuer. Upon such notice, the commissioner may, in addition to the penalties in Subsection C of this Section, issue and cause to be served upon such health insurance issuer an order requiring the health insurance issuer to cease and desist from any violation.

B. Any health insurance issuer who violates a cease and desist order issued by the commissioner pursuant to this Subpart while such order is in effect shall be subject to one or more of the following at the commissioner's discretion:

(1) A monetary penalty of not more than twenty-five thousand dollars for each act or violation and every day the health insurance issuer is not in compliance with the cease and desist order, not to exceed an aggregate of two hundred fifty thousand dollars for any six-month period.

(2) Suspension or revocation of the health insurance issuer's certificate of authority to operate in this state.

(3) Injunctive relief from the district court of the district in which the violation may have occurred or in the Nineteenth Judicial District Court.

C. As a penalty for violating this Subpart, the commissioner may refuse to renew, or may suspend or revoke the certificate of authority of any health insurance issuer, or in lieu of suspension or revocation of a certificate of authority, the commissioner may levy a monetary penalty of not more than one thousand dollars for each act or violation, not to exceed an aggregate of two hundred fifty thousand dollars.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq., except as otherwise provided by this Subpart. If a health insurance issuer has demanded a timely hearing, the penalty, fine, or order by the commissioner shall not be imposed until such time as the division of administrative law makes a finding that the penalty, fine, or order is warranted in a hearing held in the manner provided in Chapter 12 of this Title.

Added by Acts 2014, No. 718, § 1, eff. June 18, 2014.

SUBPART E. MEDICARE SUPPLEMENT MINIMUM STANDARDS

§ 1111. 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.

(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), (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. 22:1967.

I. Rules and regulations promulgated pursuant to this Section shall be subject to the Administrative Procedure Act.[1]

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 for premiums for Medicare supplement policies shall be made only as follows:

(1) By check, money order, credit or debit card, or bank draft made payable to the insurer.

(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.

Renumbered from R.S. 22:224 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 146, § 1, eff. Jan. 1, 1982. Amended by Acts 1989, No. 447, § 1, eff. Sept. 1, 1989; Acts 1990, No. 656, § 1; Acts 1992, No. 428, § 1, eff. July 1, 1992; Acts 1997, No. 633, § 1, eff. July 3, 1997; Acts 2011, No. 360, § 2, eff. June 29, 2011.

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

SUBPART F. MEDICAL NECESSITY REVIEW ORGANIZATIONS [REPEALED]

Repeal of Subpart; Enactment of Chapter; Delayed Effective Date—Acts 2013, No. 326

Acts 2013, No. 326, § 2 repealed Subpart F, "Medical Necessity Review Organizations" of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes, comprised of R.S. 22:1121 to 22:1144. Section 1 of Act 326 adds Chapter 18, "Internal Claims and Appeals Process and External Review Act", of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2391 to 22:2453. Act 326 also amends provisions of R.S. 22:821. Section 3 provides a January 1, 2015 effective date for Act 326.

§§ 1121 to 1124. Repealed by Acts 2013, No. 326, § 2, eff. Jan. 1, 2015

§ 1125. Repealed by Acts 2009, No. 33, § 2

§§ 1126 to 1144. Repealed by Acts 2013, No. 326, § 2, eff. Jan. 1, 2015

SUBPART G. DENTAL SERVICE CONTRACTORS

§ 1151. Definitions

For the purposes of this Subpart, 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.

Renumbered from R.S. 22:1510 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 461, § 1.

§ 1152. 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 Subpart, 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.

Renumbered from R.S. 22:1511 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 461, § 1.

§ 1153. 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.

Renumbered from R.S. 22:1512 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1981, No. 461, § 1.

§ 1154. 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.

Renumbered from R.S. 22:1513 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1985, No. 441, § 1, eff. July 12, 1985. Amended by Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2004, No. 607, § 1.

§ 1155. 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 issued in

the United States in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review. Subsequent to an initial denial, the licensed dentist making the adverse determination shall not be an employee of the dental service contractor or dental insurer. Any written communication to an insured or a dentist that includes or pertains to a denial of benefits for all or part of a claim on the basis of a lack of medical necessity shall include the name, applicable speciality designation, license number together with state of issuance, and the direct telephone number of the licensed dentist making the adverse determination.

Renumbered from R.S. 22:1531.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 294, § 1. Amended by Acts 2012, No. 648, § 1.

§ 1156. 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.

Renumbered from R.S. 22:213.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 329, § 1.

§ 1157. Dental reimbursement or payments

A. As used in this Section, the following definitions shall apply:

(1) "Covered person" means any subscriber, enrollee, member, or participant in a dental plan, or his dependent, for whom benefits are payable when that person receives dental health care services rendered or authorized by a licensed dentist.

(2) "Covered service" means any dental service rendered or authorized by a licensed dentist on a covered person for which a dental service contractor or insurer is required to pay benefits to the dentist under a contractual agreement with such dentist. Such a service includes any service on which reimbursement is limited by a deductible, copayment, coinsurance, waiting period, annual maximum, or frequency limitation.

(3) "Dental plan" means any insurance policy, benefit plan, or dental service contract providing for the payment of benefits for dental health care services.

B. No dental plan that is delivered, renewed, issued for delivery, or otherwise contracted for in this state may require that a dentist provide dental health care services to a covered person at a particular fee unless such services are covered services for which benefits are paid under a contract with such dentist.

C. Nothing in this Section shall prohibit a dental service contractor or insurer from offering a dentist optional agreements for participation in a dental plan in which a dentist may choose to participate either with or without a provision to provide discounts to covered persons for non-covered services provided that all of the following apply:

(1) No dental service contractor or insurer may restrict in any manner the choice of any dentist to participate in the plan with or without an optional agreement providing for discounts on non-covered services except that the option for any dentist choosing to participate in the plan under such an optional agreement to cease providing such discounts under said optional agreement but still continue participating in the plan may be limited to each time said optional agreement is up for renewal.

(2) The provision for discounts on non-covered services shall be the only material difference between agreements entered into with a dentist who accepts such an optional agreement and those with a dentist who accepts a contract without said optional agreement.

Added by Acts 2010, No. 940, § 1, eff. Jan. 1, 2011.

Application to Existing Contracts—Acts 2010, No. 940

Section 3 of Acts 2010, No. 940 (§ 1 of which enacted this section) provides:

"Section 3. The provisions of this Act shall not apply to contracts already in

existence until the renewal or extension date of such contracts."

SUBPART H. DENTAL REFERRAL PLANS

§ 1161. Purpose

The purpose of this Subpart 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.

Renumbered from R.S. 22:2028 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1050, § 1.

§ 1162. Definitions

As used in this Subpart, 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.

Renumbered from R.S. 22:2029 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1050, § 1. Amended by Acts 1997, No. 1125, § 1, eff. Aug. 15, 1997; Acts 1997, No. 1439, § 1, eff. July 15, 1997.

§ 1163. 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.

Renumbered from R.S. 22:2030 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1050, § 1.

§ 1164. Procedure for registration

A. An applicant for registration shall:

(1) Submit an application to the commissioner.

(2) Pay the application fee established by this Subpart.

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.

Renumbered from R.S. 22:2031 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1050, § 1.

§ 1165. Expiration and renewal of registration

A. Registration pursuant to this Subpart 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 Subpart.

(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.

Renumbered from R.S. 22:2032 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1050, § 1.

§ 1166. Rules and fees

Fees for initial and renewal application shall be two hundred fifty dollars.

Renumbered from R.S. 22:2033 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 1050, § 1.

§ 1167. 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 Subpart, 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.

Renumbered from R.S. 22:2034 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 282, § 1, eff. June 10, 2003.

SUBPART I. LONG TERM CARE INSURANCE

§ 1181. Purpose

The purposes of this Subpart 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.

Renumbered from R.S. 22:1731 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989. Amended by Acts 1997, No. 308, § 1, eff. June 17, 1997.

§ 1182. Scope

The requirements of this Subpart shall apply to policies delivered or issued for delivery in this state on or after September 1, 1989. Renewal policies shall comply with this Subpart, as amended. This Subpart is not intended to supersede the obligations of entities subject to this Subpart to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Subpart, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Renumbered from R.S. 22:1732 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989. Amended by Acts 1993, No. 658, § 1, eff. Jan. 1, 1994; Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

§ 1183. Short title

This Subpart may be known and cited as the "Long-Term Care Insurance Act".

Renumbered from R.S. 22:1733 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989.

§ 1184. Definitions

Unless the context requires otherwise, the following definitions in this Section shall apply for purposes of this Subpart:

(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 Subpart.

(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.

Renumbered from R.S. 22:1734 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989. Amended by Acts 1993, No. 658, § 1, eff. Jan. 1, 1994; Acts 1997, No. 308, § 1, eff. June 17, 1997; Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

§ 1185. 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. 22:1184(4)(d), unless this state has made a determination that such requirements have been met.

Renumbered from R.S. 22:1735 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989. Amended by Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

§ 1186. 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. 22:1184(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. 22:1184(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. 22:1186(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. 22:1186(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 certificate holder, 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 Subpart.

Renumbered from R.S. 22:1736 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989. Amended by Acts 1993, No. 658, § 1, eff. Jan. 1, 1994; Acts 1997, No. 308, § 1, eff. June 17, 1997; Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

§ 1187. 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. 22:931. In all other situations, this Section shall apply to life insurance policies that accelerate benefits for long-term care.

Renumbered from R.S. 22:1737 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 448, § 1, eff. Sept. 1, 1989. Amended by Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

§ 1188. 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 certificate holder 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 certificate holder 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. 22:1184(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

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.

Renumbered from R.S. 22:1738 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

§ 1188.1. Prompt payment of clean claims

A. For purposes of this Section:

(1) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred or particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

B. Within thirty business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and either of the following:

(1) That the insurer is declining to pay all or part of the claim and the specific reason or reasons for denial.

(2) That additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary.

C. Within thirty business days after receipt of all requested additional information pursuant to Paragraph (B)(2) of this Section, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice that the insurer is declining to pay all or part of the claim and the specific reason or reasons for denial.

D. If an insurer fails to comply with Subsection B or C of this Section, such insurer shall pay interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid forty-five business

days after the receipt of the claim pursuant to Subsection B of this Section or after receipt of all requested additional information pursuant to Subsection C of this Section. The interest payable pursuant to this Subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

E. The provisions of this Section shall not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

F. Any violation of this Section by an insurer if committed flagrantly and in conscious disregard of the provisions of this Section with such frequency as to constitute a general business practice shall be considered a violation of R.S. 22:1963 et seq.

Added by Acts 2012, No. 91, § 1.

§ 1189. 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, independent review of benefit determinations, penalties, and reporting practices for long-term care insurance.

Renumbered from R.S. 22:1739 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 780, § 1, eff. Jan. 1, 2005. Amended by Acts 2012, No. 307, § 1.

§ 1190. Administrative procedure

Regulations adopted pursuant to this Subpart shall be adopted in accordance with the provisions of the Administrative Procedure Act. [1]

Renumbered from R.S. 22:1740 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

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

§ 1191. 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.

Renumbered from R.S. 22:1741 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 780, § 1, eff. Jan. 1, 2005.

SUBPART J. LOUISIANA HEALTH PLAN

§ 1201. 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 ensure 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, 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 Subpart 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. The Louisiana Health Plan was created to provide health care coverage for individuals to whom comprehensive health care coverage is not available in the individual health insurance market because of preexisting health conditions. As of January 1, 2014, federal law provides that health insurance carriers in the individual market cannot reject applicants for health insurance coverage based upon the presence of preexisting health conditions or exclude health care coverage for preexisting conditions.

Renumbered from R.S. 22:231 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1997, No. 1154, § 1, eff. Jan. 1, 1998; Acts 1999, No. 163, § 1; Acts 1999, No. 294, § 1; Acts

2003, No. 528, § 1, eff. June 24, 2003; Acts 2008, No. 21, § 1; Acts 2013, No. 325, § 1, eff. June 17, 2013.

§ 1202. Definitions

As used in this Subpart:

(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 plan to eligible persons as defined by R.S. 22:1207.

(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.[1]

(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. 22:1061(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. 22:1000(A)(2)(a).

(10) "Federally defined eligible individual" means an individual as defined by R.S. 22:1073(B).

(11) "Government plan" has the meaning given such term under R.S. 22:1061(5)(g).

(12) "Group health benefit plan" means an employee welfare benefit plan as defined by R.S. 22:1061(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. 22:242(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. 22:242(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 Subpart. 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. 22:1061(1)(b).

(21) "Medicaid" means coverage provided under the state plan for Title XIX of the Social Security Act, 42 USC 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. 22:1203.

(25) "" means the plan of operation of the plan, including articles, bylaws, and operating rules, adopted by the board pursuant to R.S. 22:1205.

(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.

Renumbered from R.S. 22:232 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1991, No. 574, § 1, eff. July 16, 1991; Acts 1997, No. 1154, § 1, eff. Jan. 1, 1998; Acts 1999, No. 163, § 1; Acts 1999, No. 294, § 1; Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2005, No. 154, § 1, eff. June 28, 2005; Acts 2008, No. 21, § 1.

[1] See, inter alia, 29 U.S.C.A. §§ 1001 et seq., 1021 et seq.

§ 1203. 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. 22:1205 and shall exercise its powers through a board of directors established by R.S. 22:1204. 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. 42:11 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. 42:16 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. 22:1208.

(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 Subpart J of Part III of this Chapter.

Renumbered from R.S. 22:233 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1997, No. 1154, § 1, eff. Jan. 1, 1998; Acts 1999, No. 163, § 1; Acts 1999, No. 294, § 1; Acts 2012, No. 271, § 1.

§ 1204. 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 America's Health Insurance Plans, 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 Subpart, 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 Subpart.

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, § 2, eff. Jan. 1, 1998.

Renumbered from R.S. 22:234 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1991, No. 574, § 1, eff. July 16, 1991; Acts 1992, No. 377, § 1, eff. June 17, 1992; Acts 1999, No. 163, § 1; Acts 2004, No. 368, § 1, eff. June 23, 2004; Acts 2008, No. 21, § 1.

§ 1205. 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 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. 22:1209 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 Subpart as the board in its discretion deems necessary and proper.

(6) Provide the details of the calculation of each participating insurer's assessment.

(7) Develop an orderly plan of cessation (dissolution plan).

(a) It is the intent of the legislature by the enactment of this Paragraph to provide for the orderly cessation of the Louisiana Health Plan's operation on December 31, 2013.

(i) The Louisiana Health Plan shall cease enrollment and coverage under the plan by January 1, 2014, as required by federal law.

(ii) No provision contained in this Section shall prohibit the Louisiana Health Plan from ceasing coverage or enrollment in the plan prior to January 1, 2014, if approved by the commissioner, in a superseding plan of operation as provided for in this Section.

(b) After paying health insurance claims for plan coverage, meeting all other obligations of the board set forth by this Section, and taking all reasonable steps, including those set forth by this Section, to timely and efficiently assist in the transition of individuals receiving plan coverage to the individual health insurance market, the board shall cease operating the High Risk Pool.

(c) The board may take all actions it deems necessary to cease enrollment for plan coverage by undertaking the following actions:

(i) Provide at least ninety days notice to current policyholders of plan termination.

(ii) Terminate all existing plan coverage at the end of the calendar day on December 31, 2013, provided that there is a minimum of one individual health insurance company authorized to provide individual health insurance coverage in the state at a rate not to exceed the usual and customary rate as of January 1, 2014. In the absence of any other individual health insurance company authorized to provide individual health insurance coverage in this state, the Louisiana Health Plan shall continue to provide such coverage until there is a minimum of one individual health insurance company authorized to provide individual health insurance coverage in this state on or after January 1, 2014.

(iii) Amend plan policies and provide adequate notice to policyholders, agents of policyholders, and providers that in order for such persons to be reimbursed, a claim for plan services is required to be filed by the earlier of one hundred eighty days after the plan coverage ends on December 31, 2013, or three hundred sixty-five days after the date of service giving rise to the claim.

(d) This Section does not require the board to revise plan benefits to comply

with federal law or to maintain plan coverage for any individual after December 31, 2013.

(e) After plan coverage terminates pursuant to this Section, the board shall take reasonable steps to dissolve all significant operation of the plan by December 31, 2015.

(f) Notwithstanding any other provision of this Subsection, in order to facilitate an efficient cessation of operations, the following provisions shall apply:

(i) Until the cessation of Louisiana Health Plan's operations, the board may continue to use existing contractors without the need to issue competitive requests for proposals.

(ii) The board shall remain in effect in accordance with the provisions of R.S. 22:1204. The term of each board member shall be extended until the date the High Risk Pool concludes all business and the commissioner of insurance has certified the cessation of operations in accordance with Subparagraph (j) of this Paragraph.

(g) By August 30, 2013, the board shall submit to the commissioner a plan of operation, to be approved by the commissioner. Such plan of operation shall include a dissolution plan and shall supersede the current plan of operation in order to implement with the action required by this Paragraph. The new plan of operation shall go into effect upon signature by the commissioner.

(h) Billing of service charges pursuant to R.S. 22:1209 shall cease for claims incurred before January 1, 2014. Final service charge fees and reports shall be due and payable on January 31, 2014. Collection of all service charges legally due shall continue until cessation of operations. Nothing herein shall prohibit the auditing of any and all eligible providers, employers, insurance arrangements, or insurers.

(i) Effective December 31, 2013, fees assessed to participating health insurers and insurance arrangements under R.S. 22:1210 shall cease. Billing of the assessment based on participating health insurer premiums from calendar year 2013 shall be made no later than February 10, 2014. Payment of the assessment shall be made by the participating health insurers no later than March 31, 2014. Any participating health insurer that has not paid the assessment for calendar year 2013 by the March 31, 2014, deadline shall be reported to the commissioner for sanctions. Sanctions for refusal to timely pay a required assessment shall include the sanctions enumerated in R.S. 22:13 or 16, at the discretion of the commissioner.

(j) The commissioner shall certify the cessation of operations of each pool under the Louisiana Health Plan. The High Risk Pool and HIPAA Plan may be certified as having completed the cessation of operations separately or together, at the commissioner's discretion. The board may also submit the completed dissolution plan at different times based upon the finality of claim submissions or other factors.

(i) If the board has excess HIPAA funds after the commissioner certifies the cessation of operations of the HIPAA Plan in accordance with the provisions of this Subsection, the excess funds shall be returned to the participating insurer

on the same basis upon which each participating insurer was assessed in accordance with the provisions of R.S. 22:1210 during calendar years 2013 and 2014.

(ii) If the board has excess High Risk Pool funds after the commissioner certifies the cessation of operations of the High Risk Pool in accordance with the provisions of this Subparagraph, the High Risk Pool funds shall be returned to the state general fund.

(k)(i) By March 1, 2016, the board or liquidator shall file a report with both the House Committee on Insurance and the Senate Committee on Insurance and the commissioner. Such report shall signify completion of the requirements of this Subsection and shall include an independent auditor's report on the financial statements of the pool. Such report shall be submitted in lieu of the written report of operation of the plan required by R.S. 22:1204(F). The board or liquidator may amend such report at a later date if necessary to complete the cessation of operations of the High Risk Pool.

(ii) Upon a satisfactory review of the board's compliance with the cessation of operations provisions of this Subsection, the commissioner shall certify that the business of the High Risk Pool has concluded in accordance with state law and shall publish the certification on the Department of Insurance website.

(l)(i) Upon certification in accordance with Subparagraph (j) of this Paragraph, the operations of the High Risk Pool are terminated.

(ii) The state attorney general shall defend any legal action that may arise against the plan, the board, or the employees of the plan that is filed after the commissioner's certification of cessation of operations. This defense shall include, when appropriate, a request for dismissal of any such action.

Renumbered from R.S. 22:235 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1999, No. 163, § 1; Acts 2010, No. 123, § 1, eff. June 8, 2010; Acts 2013, No. 325, § 1, eff. June 17, 2013.

§ 1206. 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 Subpart, 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 Subpart.

(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 and nonfederally defined individuals.
(i) For federally defined individuals, 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, if applicable. 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. 22:1210, 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) Rates for nonfederally defined individuals. For nonfederally defined individuals, 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, if applicable. 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 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, 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 one hundred ten percent of rates established as applicable for individual standard risks or rates established for other individuals provided coverage by or through the plan, provided such rates shall not exceed the maximum amount of two hundred percent of rates applicable to individual standard rates. In no instance shall the rates discriminate between covered individuals on the basis of health-related factors.

(iii) Notwithstanding any other provision of this Subpart to the contrary, for persons eligible under a federal waiver pursuant to R.S. 22:1207(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 Subpart. The board may authorize the Louisiana Health Plan to provide for the nonfederal share of such premium subsidy. Nothing herein shall permit rates to be calculated other than as described in this Subpart, 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 Subpart to the contrary, for persons eligible under a federal waiver pursuant to R.S. 22:1207(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 Subpart. 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 Subpart, 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. 22:1207 or 1073(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 Subpart.

(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.

Renumbered from R.S. 22:236 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1997, No. 1154, § 1, eff. Jan. 1, 1998; Acts 1999, No. 163, § 1; Acts 2003, No. 528, § 1, eff. June 24, 2003; Acts 2005, No. 154, § 1, eff. June 28, 2005; Acts 2008, No. 21, § 1.

§ 1207. 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 Subpart, 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. 22:1202.

(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. 22:1202.

(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.

(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 loss of eligibility, 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 immunosuppression 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. 22:1213(F)(3), for persons of comparable age, sex, and geographical location, shall be eligible for coverage as provided in this Subpart.

(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 pre-existing conditions, as provided in R.S. 22:1213(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. 22:1961 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.

Renumbered from R.S. 22:237 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by 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; Acts 2008, No. 21, § 1.

§ 1208. Administration

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.

Renumbered from R.S. 22:238 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1999, No. 163, § 1; Acts 2004, No. 368, § 1, eff. June 23, 2004.

§§ 1209, 1210. Repealed by Acts 2013, No. 325, § 2, eff. Dec. 31, 2014

§ 1211. Powers and duties of the commissioner

A. In addition to the duties and powers enumerated elsewhere in this Subpart, 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, in accordance and compliance with R.S. 49:961, 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.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:239.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1154, § 1, eff. Jan. 1, 1998. Amended by Acts 1999, No. 163, § 1; Acts 2009, No. 317, § 1.

§ 1212. Miscellaneous provisions

A. Nothing in this Subpart 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 Subpart.

B. For purposes of carrying out its obligations under this Subpart, 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. 22:2093, payment of contractual obligations of an impaired or insolvent insurer shall include fees assessed under this Subpart.

C. Any unpaid fees assessed to a participating insurer shall become the liability of any continuing or successor insurer.

Renumbered from R.S. 22:239.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1154, § 1, eff. Jan. 1, 1998. Amended by Acts 1999, No. 163, § 1.

§ 1213. 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 Subpart. 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 E 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 two hundred fifty 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. Covered expenses shall be the usual, customary, and reasonable charge, as established by the board, in the locality for the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services:

(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 H 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 H 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.

(14) Services for diagnosis and treatment of mental and nervous disorders provided that a covered person may be required to pay up to a fifty percent coinsurance payment, and the plan's payment may not exceed twenty-five thousand dollars. Notwithstanding the previous provision, the department may conduct a periodic actuarial cost analysis to determine whether the plan's maximum payment for outpatient services for diagnosis and treatment of mental and nervous disorders should be adjusted.

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. 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.

E. (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)(a) The plan, with the assistance of the commissioner, 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.

(b) Standard risk rates for federally defined eligible individuals shall comply with all applicable federal laws and regulations. Initial rates for plan coverage for federally defined eligible individuals shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks. In no event shall plan rates exceed two hundred percent of rates applicable to the individual standard risks.

(c) Initial rates for plan coverage provided to nonfederally 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 nonfederally 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. In no event shall rates be lower than one hundred ten 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.

F. 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. 22:1073(A)(1)(b), except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

G. (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.

H. 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 Subpart.

I. Except as otherwise provided in this Subpart and in R.S. 22:976, 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.

Renumbered from R.S. 22:240 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by 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; Acts 2008, No. 21, § 1; Acts 2010, No. 123, § 1, eff. June 8, 2010.

§ 1214. Mandated benefits

Service charges assessed to any patient pursuant to R.S. 22:1209 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.

Renumbered from R.S. 22:241 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990.

§ 1215. Exemptions; relation to other laws

A. The plan established pursuant to this Subpart shall be exempt from any and all state and local taxes.

B. The plan and any administrator selected by the board to administer the benefits plan shall be exempt from the provisions of R.S. 22:1821.

Renumbered from R.S. 22:242 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 131, § 1, eff. Sept. 1, 1990. Amended by Acts 1999, No. 163, § 1; Acts 2008, No. 21, § 1.

§ 1215.1. Peremption

Dissolution of the operations of the Louisiana Health Plan requires the expeditious determination of its outstanding liabilities. As such, each of the following provisions shall apply:

(1) Any action against the plan, the board, the employees of the plan, or any combination thereof shall be subject to a peremptive period ending on December 31, 2014, at which time the right to assert a cause of action shall be extinguished.

(2) All appeals by policyholders or providers must be made within the guidelines of the policy. In no event shall any appeal by a policyholder or provider be commenced after September 30, 2014.

(3) Notwithstanding the provisions of this Section, nothing herein shall limit the immunity from liability provided by R.S. 22:1203(D).

Added by Acts 2013, No. 325, § 1, eff. June 17, 2013.

SUBPART K. LIMITATIONS ON ASSIGNMENT OF OBLIGATIONS

§ 1221. Definitions

For purposes of this Subpart, 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 Subpart I of Part I of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

Renumbered from R.S. 22:421 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 417, § 1.

§ 1222. 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. 22:631 et seq.), prompt payment of claims (R.S. 22:1831 et seq.), and medical necessity review (R.S. 22:1121 et seq.).

B. This Subpart shall not apply to health insurance coverage for services under the terms of a carve-out agreement. Nor does this Subpart 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. 22:1831 et seq. and R.S. 22:1121 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 Subpart.

Renumbered from R.S. 22:422 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 417, § 1.

SUBPART L. TRANSPLANT CENTERS

§ 1231. 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.

Renumbered from R.S. 22:1450.21 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 207, § 1.

§ 1232. 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.

Renumbered from R.S. 22:1450.22 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 207, § 1.

§ 1233. Documentation

A. The provisions of this Subpart 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.

Renumbered from R.S. 22:1450.23 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 207, § 1.

SUBPART M. LOUISIANA SAFETY NET HEALTH INSURANCE PROGRAM

§ 1241. 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 Subpart 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".

Renumbered from R.S. 22:3101 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003.

§ 1242. Definitions

As used in this Subpart:

(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 intellectual or physical disability, 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 Subpart, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, and nonfederal government plans subject to the provisions of Subpart B of Part II of Chapter 6 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.

Renumbered from R.S. 22:3112 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003. Amended by Acts 2004, No. 493, § 1, eff. June 25, 2004; Acts 2014, No. 811, § 11, eff. June 23, 2014.

§ 1243. Eligibility

The following are eligible for the program:

(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 Subpart, 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.

Renumbered from R.S. 22:3102 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003. Amended by Acts 2004, No. 493, § 1, eff. June 25, 2004.

§ 1244. 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 Subpart. 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 R.S. 22:972, 973, 975-983, 985-990, 992, 993, 999-1008, 1010-1014, 1021-1042, 1044-1048, 1091-1096, 1111, and 1156, R.S. 22:972 et seq., R.S. 22:984, and 1061 through 1079, 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 Subpart. 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 Subpart, 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 Subpart, 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 Subpart.

Renumbered from R.S. 22:3103 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003. Amended by Acts 2004, No. 493, § 1, eff. June 25, 2004.

§ 1245. 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. 22:1243.

(2) Relative to the program network criteria, as set forth in R.S. 22:1244, 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.

Renumbered from R.S. 22:3104 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003. Amended by Acts 2004, No. 493, § 1, eff. June 25, 2004.

§ 1246. 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 Subpart and the producer is required to meet all applicable producer provisions enumerated in this Title.

Renumbered from R.S. 22:3105 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003. Amended by Acts 2004, No. 493, § 1, eff. June 25, 2004.

§ 1247. 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 Subsection 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.

Renumbered from R.S. 22:3106 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003.

§ 1248. 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. 22:1247 and 1249.

Renumbered from R.S. 22:3107 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003.

§ 1249. 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. 22:972(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. 22:1012 and 887(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. 22:887(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.

Renumbered from R.S. 22:3108 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003. Amended by Acts 2004, No. 493, § 1, eff. June 25, 2004.

§ 1250. Construction of policy

A policy issued in violation of this Subpart 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 Subpart, the rights, duties, and obligations of the health insurance issuer, the enrollee and the insured shall be governed by the provisions of this Subpart.

Renumbered from R.S. 22:3109 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003.

§ 1251. Statutory construction; relationship to other laws

Except as otherwise provided in this Subpart, 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 Subpart.

Renumbered from R.S. 22:3110 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003.

§ 1252. Scope and limitation

A. It is not the purpose of this Subpart 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 Subpart shall be exempt from the applicability of all other insurance laws of this state, except the Unfair Trade Practices provisions of Part IV of Chapter 7 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 Subpart, or where such laws are specifically incorporated herein by reference.

Renumbered from R.S. 22:3111 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 528, § 1, eff. June 24, 2003.

SUBPART N. THE LOUISIANA DISCOUNT MEDICAL PLAN ACT

Redesignation—Acts 2009, No. 503

This Subpart N of Part III of Chapter 4 of Title 22, consisting of R.S. 22:1260.1 to 22:1260.11, was redesignated from Chapter 18 of Title 22, consisting of R.S. 22:2391 to 22:2401, pursuant to § 3 of Acts 2009, No. 503 and the statutory revision authority of the Louisiana State Law Institute.

§ 1260.1. Purpose

The purpose of this Chapter shall be to protect the public from inappropriate, unfair, and deceptive marketing, sales or enrollment practices and to facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical services.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2391 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.2. Definitions

As used in this Chapter, unless the context clearly indicates otherwise, the following definitions shall apply:

(1) "Affiliate" shall mean a person that, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with an insurance company or health maintenance organization licensed by this state.

(2) "Commissioner" shall mean the commissioner of insurance.

(3) "Discount medical plan card" shall mean a card or any other purchasing mechanism or device, which is not insurance, that purports to offer discounts or access to discounts in health-related purchases from health care providers.

(4) "Discount medical plan" shall mean a business arrangement or contract in which a person, in exchange for fees, dues, charges or other valuable consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. This term shall not include any plan that does not charge a membership or other fee to use the plan's discount medical card or discount medical plan provided by an insurer or health maintenance organization where the discount plan is provided at no cost to the insured or member and is offered due to coverage with the insurer or health maintenance organization. This term shall not include any agreements related to medical services which are provided to injured workers under the requirements of Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, or ambulance membership service agreements.

(5) "Discount medical plan organization" shall mean any person or organization that operates a discount medical plan and contracts with providers, provider networks or other discount medical plan organizations to offer access to medical services at a discount and determines the charge to discount medical plan members. Entities that are licensed pursuant to this Title shall not be subject to the provisions of R.S. 22:2393, 2394 and 2398.

(6) "Discount medical plan provider" shall mean any person that has contracted directly or indirectly with a discount medical plan organization to provide medical services.

(7) "Entity" shall mean a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(8) "Facility" shall mean an institution providing medical services or a health care setting, to include, but not be limited to, a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a rehabilitation center and a diagnostic, laboratory or imaging center.

(9) "Health care provider" shall mean any person licensed, certified, or registered in this state to provide health care services, including but not limited to physicians, hospitals, home health agencies, chiropractors, pharmacies and dentists.

(10) "Health care provider network" shall mean an entity which directly or indirectly contracts with a health care provider and has contractual rights to negotiate on behalf of those health care providers with a discount medical plan organization to provide medical services to members of a discount medical plan.

(11) "Individual" shall mean a natural person.

(12) "Marketer" shall mean any person who markets, promotes, sells or distributes a discount medical plan, including but not limited to a private label entity that places its name on and markets or distributes a discount medical plan.

(13) "Medical services" shall mean any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including but not limited to physician care, inpatient care, outpatient care, hospital surgical services, emergency services, ambulance services, chiropractic services, dental services, audiology services, vision care services, mental health services, substance abuse services, podiatric care services, laboratory services and medical equipment and supplies.

(14) "Member" shall mean any individual who pays valuable consideration to receive the purported benefits of a discount medical plan.

(15) "Person" shall mean an individual or an entity.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2392 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.3. Registration

No discount medical plan organization shall conduct business or otherwise operate in this state unless it is registered with the commissioner.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2393 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.4. Procedure for registration

A. An applicant for registration shall submit an application to the commissioner and pay the application fee of two hundred fifty dollars.

B. The application shall be on a form prescribed by the commissioner, accompanied by any supporting documentation and shall be signed and verified by the applicant. The information required by the application shall include the following items:

(1) The articles of incorporation or articles of organization and name of the entity operating the discount medical plan and any trade or business names used by that entity in connection with the operation of the discount medical plan.

(2) The names and addresses of every officer and director of the entity operating the discount medical 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, ten percent or more of the entity operating the discount medical plan.

(4) The principal place of business of the discount medical plan.

(5) A general description of the operation of the discount medical plan which includes a statement that the plan does not provide indemnity insurance coverage for medical services.

(6) A sample copy of a contract with a member which includes a general description of the member's rights under the discount medical plan.

(7) A sample copy of a contract, absent the fee schedule, with a health care provider which includes a general description of the health care provider's rights under the discount medical plan.

(8) A description of the proposed methods of marketing, including, but not limited to, describing the use of marketers, the use of the Internet, sales by telephone, and use of salespersons to market the discount medical plan benefits.

(9) A description of the member complaint procedures to be established and maintained by the applicant.

(10) The name and address of the applicant's Louisiana statutory agent for service of process, notice of demand, or if not domiciled in this state, a power of attorney executed by the applicant, appointing the commissioner as the true and

lawful attorney of the applicant in and for this state upon whom all law process in any legal action or proceeding against the discount medical plan organization on a cause of action arising in this state may be served.

C. A registration for purposes of this Section shall be effective for two years, unless the registration is renewed, suspended or revoked.

D. To renew the registration, no later than ninety days before its registration expires, the discount medical plan organization shall submit a renewal application on the form that the commissioner requires and the renewal fee of two hundred fifty dollars.

E. The commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a registration if the commissioner finds that any of the following conditions exist:

(1) The discount medical plan organization is not operating in compliance with this Chapter.

(2) The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising.

(3) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization.

(4) The continued operation of the discount medical plan organization would be hazardous to its members.

F. Whenever the discount medical plan organization has been found to have violated any provision of this Chapter, the commissioner may:

(1) Issue or cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation.

(2) Impose a monetary penalty of not more than two thousand five hundred dollars for each violation, but not to exceed an aggregate penalty of seventy-five thousand dollars.

(3) Nothing in this Section shall affect the authority of the commissioner to impose any other penalties provided for in this Title, or by rule, regulation, or order.

G. Each registered discount medical plan organization shall notify the commissioner immediately whenever the discount medical plan organization's registration, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.

H. A provider who provides discounts to his own patients without any cost or fee of any kind to the patient is not required to maintain a registration under this Chapter as a discount medical plan organization.

I. Nothing in this Chapter shall be construed to apply to a customer discount or membership card issued by a store or buying club for use at the store or buying club exclusively.

J. Any decision pursuant to this Chapter shall be subject to the provisions of Chapter 12 of Title 22 of the Louisiana Revised Statutes of 1950.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2394 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.5. Charges and fees; refund requirements; bundling of services

A. A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.

B. (1) If a member cancels his membership in the discount medical plan organization within the first thirty days after the date of receipt of the written document for a discount medical plan as described in R.S. 22:2397, the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds thirty dollars upon return of the discount medical plan card to the discount medical plan organization.

(2)(a) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

(b) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed and postage prepaid to the mailing address of the discount medical plan organization or emailed to the email address of the discount medical plan organization.

(c) A discount medical plan organization shall return any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

C. If the discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2395 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.6. Provider listing requirements

Each discount medical plan organization shall maintain an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. This Section applies to those providers with which the discount medical plan organization has contracted with directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2396 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.7. Marketing restrictions and disclosure requirements

A. (1) The name of the discount medical plan and the address shall be prominently displayed on all of its advertisements, marketing materials and brochures.

(2) All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in either fact or implication.

(3) Upon request, a discount medical plan organization shall submit to the commissioner all advertising, marketing materials and brochures regarding a discount medical plan.

B. A discount medical plan organization shall not do any of the following:

(1) Except as otherwise provided in this Chapter or as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures and discount medical plan cards the term "insurance."

(2) Except as otherwise provided in the laws of this state, describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits.

(3) Use in its advertisements, marketing material, brochures and discount medical plan cards the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could mislead an individual into believing that the discount medical plan is health insurance.

(4) Use language in its advertisements, marketing material, brochures and discount medical plan cards with respect to being "registered" by the department in a manner that could mislead an individual into believing that the discount medical plan is insurance or has been endorsed by this state.

(5) Make misleading, deceptive or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card.

(6) Have restrictions on access to health care providers who have contracted with a discount medical plan, except for hospital services.

C. (1) Each discount medical plan organization shall, in writing that is not less than twelve-point font, disclose on the first content page of any advertisements, marketing materials or brochures made available to the public relating to a discount medical plan and any enrollment forms given to a prospective member:

(a) That the plan is a discount plan and is not insurance coverage.

(b) That the range of discounts for medical services provided under the plan will vary depending on the type of provider and medical service received.

(c) That the plan member is obligated to pay for all medical services, but will receive a discount from those providers that have contracted with the discount medical plan organization.

(d) The toll-free telephone number and Internet website address for the registered discount medical plan organization for prospective members to obtain information about and assistance on the discount medical plan and up-to-date list of providers participating in the discount medical plan.

(2) If the initial contact with a prospective member is made by telephone, the disclosures required under Paragraph (1) of this Subsection shall be made orally and included in the written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

D. (1) In addition to the general disclosures required under Subsection C of this Section, each discount medical plan shall provide the following:

(a) To each new member, at the time of enrollment, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan.

(b) To each new member a written document that contains the terms and conditions of the discount medical plan.

(2) The written document required under Subparagraph (1)(b) of this Subsection shall include information on the following:

(a) The name of the member.

(b) The benefits to be provided under the discount medical plan.

(c) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges.

(d) The mode of payment of any processing fees and periodic charges and procedure for changing the mode of payment.

(e) Any limitations, exclusions or exceptions regarding the receipt of discount medical plan benefits.

(f) Any waiting periods for certain medical services under the discount medical plan.

(g) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf.

(h) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds.

(i) Renewal, termination and cancellation terms and conditions.

(j) Procedures for adding new members to a family discount medical plan, if applicable.

(k) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his state insurance department.

(l) The name and mailing address of the registered discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices and file complaints.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2397 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.8. Notice of change in name or address

Each discount medical plan organization shall provide the commissioner at least thirty days advance notice of any change in the discount medical plan organization's name, address, principal business address, mailing address or Internet website address.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2398 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.9. Penalties

A. In addition to the penalties and other enforcement provisions of this Chapter, any person who willfully violates the provisions of this Chapter shall be subject to civil penalties of up to two thousand five hundred dollars per violation.

B. A person that willfully operates as or aids and abets another person's operating as a discount medical plan organization in violation of R.S. 22:2397(B) commits insurance fraud and shall be subject to payment of a monetary penalty of not more than one thousand dollars for each and every act or violation, but not to exceed one hundred thousand dollars, unless the person knew or reasonably should have known he was in violation of R.S. 22:2397(B), in which case the penalty shall not be more than twenty-five thousand dollars for each and every violation not to exceed an aggregate penalty of two hundred-fifty thousand dollars in any six-month period, as if the unregistered discount medical plan organization were an unauthorized insurer, and the fees, dues, charges or other consideration collected from the members by the unregistered discount medical plan organization or marketer were insurance premium.

C. A person that collects fees for purported membership in a discount medical plan, but purposefully fails to provide the promised benefits commits a theft and upon conviction is subject to the criminal penalties for theft enumerated in R.S. 14:67. In addition, upon conviction, the person shall be ordered to pay restitution to persons aggrieved by the violation of this Chapter. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2399 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan

organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.10. Injunctions

A. In addition to the penalties and other enforcement provisions of this Chapter, the commissioner may seek both temporary and permanent injunctive relief when any of the following occur:

(1) A discount medical plan is being operated by a person or entity that is not registered pursuant to this Chapter.

(2) Any person, entity or discount medical plan organization has engaged in any activity prohibited by this Chapter or any regulation adopted pursuant to this Chapter.

B. The commissioner's authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to the Louisiana Administrative Procedure Act.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:2400 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

§ 1260.11. Regulations

The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Chapter. The rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Added by Acts 2008, No. 442, § 1, eff. Jan. 1, 2009. Amended by Acts 2009, No. 317, § 1. Redesignated from R.S. 22:2401 by Acts 2009, No. 503, § 3.

Effective Date; Compliance—Acts 2008, No. 442

Section 2 of Acts 2008, No. 442 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall become effective on January 1, 2009. A person doing business in or from this state as a discount medical plan organization before the effective date shall have until July 1, 2009, to come into compliance with the requirements of this Act."

SUBPART O. PHYSICIAN AND PROVIDER NOTIFICATION OF PATIENTS IN HEALTH INSURANCE EXCHANGE GRACE PERIOD ACT

§ 1260.31. Short title

This Subpart shall be known and may be cited as the "Physician and Provider Notification of Patients in Health Insurance Exchange Grace Period Act".

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.32. Definitions

As used in this Subpart, the following words shall have the following meanings, unless the context clearly indicates otherwise:

(1) "Enrollee" means a qualified individual or qualified employee enrolled in a qualified health plan. An enrollee is generally a person eligible for services covered by a specific health insurance plan in the exchange.

(2) "Grace period" is a period that applies to recipients of advance payments of the premium tax credit allowed for certain individuals to purchase health insurance coverage on the exchange. The grace period provides three consecutive months for an enrollee to pay a delinquent premium when that enrollee has paid a premium at least one full month during the benefit year. The grace period begins when the enrollee fails to pay the premium for a particular month.

(3) "Health insurance exchange" or "exchange" means a governmental agency or nonprofit entity that meets the applicable standards of the Patient Protection and Affordable Care Act and makes qualified health plans available to qualified individuals and qualified employers.

(4) "Qualified health plan" means a health insurance plan that has in effect a certification that the qualified health plan meets applicable state or federal standards required for participation in a health insurance exchange. These may include minimum standards for essential health benefits, deductibles, copayments, out-of-pocket maximum amounts, and other requirements.

(5) "Qualified health plan issuer" means a health insurance issuer that offers a qualified health plan in accordance with a certification from an exchange.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.33. Notice requirements

A. Timing of notice to physician or provider of grace period status.

(1) When a physician or other healthcare provider or his representative requests information regarding an enrollee from a qualified health plan issuer about eligibility, coverage, or health plan benefits, or the status of a claim or claims for services provided, and the request or service is for a date within the second or third month of a grace period, the qualified health plan issuer shall clearly identify that the applicable enrollee is in the grace period and provide additional information as required by this Subpart.

(2) Unless the qualified health plan issuer makes the notice available on its website or by other electronic means, the qualified health plan issuer shall provide the notice through the same medium through which the physician or other healthcare provider or his representative sought the information from the qualified health plan issuer pursuant to Paragraph (1) of this Subsection.

(3) The information provided about the enrollee's grace period status shall be binding on the qualified health plan pursuant to this Subpart.

B. Specific notice requirements.

(1) If the qualified health plan issuer informs the physician or other healthcare provider or his representative that the enrollee is eligible for services but not that the enrollee is in the grace period, the determination shall be binding on the qualified health plan issuer and it shall pay the claims for covered services in accordance with the qualified health plan.

(2) The binding determination shall preclude the qualified health plan issuer from seeking to recoup payment from the physician or other healthcare provider for services rendered during the grace period.

(3) If the qualified health plan issuer informs the physician or other healthcare provider that the enrollee is in a grace period, he shall then provide further notification pursuant to Subsection C of this Section.

C. Contents of notice. The notice to the physician or other healthcare provider shall include but not be limited to the following:

(1) Purpose of the notice.

(2) The full legal name of the enrollee and any unique identifying numbers.

(3) The name of the qualified health plan.

(4) The unique health plan identifier of the qualified health plan.

(5) The name of the qualified health plan issuer.

(6) The specific date upon which the grace period for the enrollee began and the specific date upon which the grace period will expire.

D. Required information. In a conspicuous location on a qualified health plan website, the qualified health plan issuer shall provide the following information:

(1) Whether the qualified health plan issuer will hold any claims of the physician or other healthcare provider for services that the physician or other healthcare provider furnishes to the enrollee during the grace period.

(2) A statement indicating that should the qualified health plan issuer indicate that it will pay some or all of the claims for services provided to an enrollee during the grace period, whether and how it will seek to recoup claims payments made to physicians or healthcare providers for services furnished during the grace period.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.34. Strict compliance required

A qualified health plan issuer shall be obligated to pay for any covered claims for services rendered during a grace period if he has failed to strictly comply with the provisions of this Subpart. Such payment shall be in accordance with the terms of the qualified health plan.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give

effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.35. Deadline for overpayment recoveries

If the qualified health plan issuer seeks to recoup or otherwise recover payments made to the physician or other healthcare provider for services furnished to an enrollee during the grace period and that enrollee's coverage is subsequently cancelled for nonpayment of premium, the qualified health plan issuer shall commence such recovery or recoupment efforts no later than sixty days after the expiration of the grace period. Any attempts to recover payments that are commenced subsequent to this sixty-day period shall be null and void.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.36. Waiver prohibited

The provisions of this Subpart cannot be waived by contract. Any contractual arrangements in conflict with the provisions of this Subpart or that purport to waive any requirements of this Subpart are null and void.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.37. Injunction

Any physician or other healthcare provider may request a court of appropriate jurisdiction to issue an injunction to enforce any provision of this Subpart.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

§ 1260.38. Rules and regulations

The commissioner of insurance shall promulgate all rules and regulations which are necessary and proper to carry out the provisions of this Subpart. All rules and regulations promulgated pursuant to this Subpart shall be in accordance with the Administrative Procedure Act.

Added by Acts 2014, No. 174, § 1.

Severability—Acts 2014, No. 174

Section 2 of Acts 2014, No. 174 provides:

"Section 2. If any provision of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are hereby declared severable. The severability provision of this Section shall be broadly construed as to give effect to each and every possible provision or application of this Act which is not specifically held invalid, unlawful, or unconstitutional."

PART IV. PROPERTY AND CASUALTY

SUBPART A. INSURANCE AND CONTRACT REQUIREMENTS IN GENERAL

§ 1261. 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. Such renewal shall be made upon a currently authorized renewal form and at the premium rate then required 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 if the policy is renewed within ten days after the date of termination.

Renumbered from R.S. 22:635 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1997, No. 702, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1262. 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 null and void.

Renumbered from R.S. 22:639 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1263. 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 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.

Renumbered from R.S. 22:670 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 257, § 1, eff. July 6, 1988. Amended by Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1264. Presumption of coverage

A. For losses that arose due to a catastrophic event for which a state of disaster or emergency was declared pursuant to law by civil officials, for those areas within the declaration, no damages to covered property shall be automatically denied by the inability of the policyholder to provide sufficient proof of loss within the time limits and requirements of the policy. The time limit for the submission of proof of loss shall be not less than one hundred eighty days. The time limit shall not commence as long as a declaration of emergency is in existence and civil authorities are denying the insured access to the property.

B. For losses that arose due to a catastrophic event for which a state of disaster or emergency was declared pursuant to law by civil officials, for those areas within the declaration, any policyholder with replacement cost provisions shall be entitled to complete repairs to the property within one year from the date of the loss or the issuance of applicable insurance proceeds, whichever is later. Adherence to this provision shall entitle the policyholder with a replacement cost provision to receive full value of the covered damage that has been repaired, without reduction due to depreciation.

C. The provisions of this Section shall be applicable to all new policies and renewal policies delivered in the state of Louisiana after April 18, 2006.

Renumbered from R.S. 22:682 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 23, § 1.

§ 1265. 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 policy's named insured, specify in writing the reason or reasons for such cancellation or refusal to renew. Such request shall be mailed or delivered to the insurer within six months after the effective date of cancellation or expiration.

(2) There shall be no liability and no cause of action of any nature against any insurer or its producers, 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 actuarially justified rate relief from the commissioner of insurance and such rate relief has been rejected by the commissioner.

B. There shall be no liability and no cause of action of any nature against the commissioner of insurance or against any insurer, its authorized representative, its producers, 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 continuous three-year period of time within the five years preceding the current policy renewal date, or if continuation of such policy endangers the solvency of the insurer. This Subsection shall not apply to an insurer that withdraws from the homeowners' insurance market in this state or to policy deductibles increased for all homeowners' policies in this 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. As used in this Subsection, the phrase "two or more claims within a continuous three-year period of time within the five years preceding the current policy renewal date" shall not include any loss incurred or arising from an "Act of God" incident which is due directly to forces of nature and exclusively without human intervention.

E. The department shall review annually every insurer that cancels or fails to

renew any insurance policy providing property, casualty, or liability insurance on any property which policy has been in effect and renewed for more than three years when the cancellation or nonrenewal is based on the reason that continuation of the policy endangers the solvency of the insurer or when based on the reason, in whole or in part, of inadequacy or insufficiency of the rate or premium for coverage after the insurer has sought actuarially justified rate relief from the commissioner and such relief has been rejected by the commissioner. Any action against an insurer taken by the department for a violation of the provisions of this Section shall remain in effect until changed or modified by the commissioner based upon the review required under the provisions of this Subsection.

F. Notwithstanding the provisions of Subsection D of this Section, an insurer may make a filing with the commissioner pursuant to R.S. 22:1464 for authorization to deviate from the provisions of Subsection D of this Section for the sole purpose of changing the policy deductible to a total deductible of not more than four percent of the value of the property being insured for named storms or hurricanes on a homeowner's policy of insurance that has been in effect for more than three years. Any insurer filing with the commissioner pursuant to this Subsection shall file with the commissioner a business plan setting forth the insurer's plan to write new business in the particular region or area of the state in which the new deductible is to apply. The commissioner's approval is to be based on the insurer's commitment to the writing of new business in the respective region or area of the state in which the new deductible is to apply. The commissioner may also approve a filing that he determines to be in the best interest of the policyholders. The commissioner may subsequently rescind his approval of any filing made pursuant to this Subsection in the event the insurer fails to write new business in accordance with the business plan. Any business plan filed shall be considered proprietary or trade secret pursuant to information under the provisions of R.S. 44:3.2 and the Uniform Trade Secrets Act. The commissioner shall provide an annual report to the legislative committees on insurance on the application and effectiveness of the provisions of this Section. The commissioner shall promulgate regulations pursuant to the Administrative Procedure Act setting forth the criteria for the filing, including any financial or other requirements that he deems necessary to act on the request by an insurer. Any regulation promulgated by the commissioner pursuant to this Subsection shall require the insurer to itemize to the insured the premium savings based on the increase in the insured's deductible.

G. No homeowner's policy of insurance shall contain any provision that would apply more than one deductible to a loss resulting from any single incident covered by the policy. Any such provision shall be null and void and unenforceable as contrary to public policy.

H. Any company which makes a filing pursuant to Subsection F of this Section shall reduce the rates paid by the individual homeowner by the amount determined to be actuarially justified by the commissioner.

I. Any authorized property and casualty insurer that avails itself of the provisions of Subsection D of this Section relative to withdrawing from the homeowners' insurance market may not issue any homeowners' insurance coverage in this state during the five-year period beginning on the date of the discontinuation of the last homeowners' insurance coverage not so renewed. The commissioner may, for good cause shown pursuant to a written request by the insurer, permit the insurer to reenter the homeowners' insurance market prior to

the expiration of the five-year period.

J. Any approved unauthorized property and casualty insurer that avails itself of the provisions of Subsection D of this Section relative to withdrawing from the homeowners' insurance market may not issue any homeowners' insurance coverage in this state during the five-year period beginning on the date of the discontinuation of the last homeowners' insurance coverage not so renewed. The commissioner may, for good cause shown pursuant to a written request by the insurer, permit the insurer to reenter the homeowners' insurance market prior to the expiration of the five-year period.

Renumbered from R.S. 22:636.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1968, No. 51, § 1. Amended by 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; Acts 2007, No. 381, § 1, eff. July 10, 2007; Acts 2008, No. 440, § 1; Acts 2008, No. 854, § 1, eff. July 9, 2008; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2014, No. 353, § 1.

§ 1266. Automobile, property, casualty, and liability insurance policies; cancellations

A. As used in this Part:

(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 private passenger vehicle that is not used as a public or livery conveyance for passengers, nor rented to others.

(b) Any other four-wheel motor vehicle with a load capacity of sixteen hundred pounds or less which is not used in the occupation, profession or business of the insured; however, this shall not apply to:

(i) Any policy issued under an automobile assigned risk plan.

(ii) Any policy insuring more than four automobiles.

(iii) 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 Subpart 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 Subpart.

(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 within a period of five years, the modification of such insured's automobile physical damage coverage by the inclusion of or a change in a deductible not exceeding five hundred 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 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 and no cause of action of any nature against any insurer or its producers, 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 a producer 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 producer shall immediately, and in no case later than ten days after the producer 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 producer 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 producer all funds paid to the insurer by the insured or his legal representative to replace the dishonored check or other negotiable instrument.

(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 producer to the insurer on behalf of the insured, except that 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 producer's or premium finance company's account currents unless the producer 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 producer. When funds are returned to the premium finance company by an insurer, the insurer shall also mail a copy of the check or other negotiable instrument to the insured at the insured's last-known address.

(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 producer of cash or a certified check, the producer 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. 22:887(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 a producer 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 producer to be returned to the insured, and the insurance premium finance company shall also mail to the insured a copy of the check or other negotiable instrument representing the amount of the payment. 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; however, 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 and no cause of action of any nature against any insurer or its producers, 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 and no cause of action of any nature against the commissioner of insurance or against any insurer, its authorized representative, its producers, 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 of 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 the 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 the 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.

M. (1) An insurance premium finance company that finances any part of an insurance policy governed by this Section shall cooperate with the department in any investigation regarding such insurance policy.

(2) Upon request by the department, the insurance premium finance company shall make available to the department all documents, correspondence, and cancellation notices related to the insurance policy that is the subject of an investigation as provided in Paragraph (1) in this Subsection that have been received or sent by the insurance premium finance company.

(3) An insurance premium finance company that violates any provision of this Section shall be subject to the monetary penalties provided for in R.S. 22:13(A).

Renumbered from R.S. 22:636.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; 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, No. 1008, § 1; Acts 1999, No. 1073, § 1; Acts 2003, No. 298, § 1; Acts 2004, No. 826, § 1; Acts 2009, No. 472, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2010, No. 901, § 1; Acts 2015, No. 37, § 1.

§ 1267. Commercial insurance; cancellation and renewal

A. This Section shall apply to commercial property insurance policies, commercial automobile insurance policies, commercial multi-peril insurance policies, workers' compensation insurance, professional errors and omissions policies, and 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 producer 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) 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. 22:1267(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. 22:1267(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) An insurer shall provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance company 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 Paragraph (1) of this Subsection 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 commissioner of insurance 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.

G. (1) An insurance premium finance company that finances any part of an insurance policy governed by this Section shall cooperate with the department in any investigation regarding such insurance policy.

(2) Upon request by the department, the insurance premium finance company shall make available to the department all documents, correspondence, and cancellation notices related to the insurance policy that have been received or sent by the insurance premium finance company.

(3) An insurance premium finance company that violates any provision of this Section shall be subject to the monetary penalties provided for in R.S. 22:13(A).

Renumbered from R.S. 22:636.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1987, No. 776, § 1. Amended by 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; Acts 2010, No. 106, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2015, No. 37, § 1.

§ 1268. Interest on refund; exception

A. Any refund due an insured by an insurer writing or delivering insurance policies excluding health insurance, life insurance, and annuities 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. However, when the insured continues to maintain a policy of insurance with the insurer, or an affiliated insurer, and the amount of the refund plus interest is twenty-five dollars or less, the insurer may credit the amount of the payment against future premiums. The insurer shall give written notice to the insured of the credit and the amount at policy renewal.

B. The provisions of this Section shall not apply to those policies issued by an insurance company which require an audit.

Renumbered from R.S. 22:637.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1977, No. 338, § 1. Amended by Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2012, No. 55, § 1.

§ 1269. 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 survivors, mentioned in Civil Code Art. 2315.1, or heirs against the insurer.

B. (1) The injured person or his survivors or heirs mentioned in Subsection A of this Section, 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 at least one of the following applies:

(a) The insured has been adjudged bankrupt by a court of competent jurisdiction or when proceedings to adjudge an insured 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.

(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 the insured may have as or for a tortfeasor within the terms and limits of the policy.

Renumbered from R.S. 22:655 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1962, No. 471, § 1; Acts 1988, No. 934, § 1, eff. Jan. 1, 1989; Acts 1989, No. 117, § 2; Acts 1992, No. 584, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1270. 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 for the policy, 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. 22:47(3) when the coverage pertains to land vehicles.

(b) Any property used primarily for business purposes.

(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.

Renumbered from R.S. 22:667 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1974, No. 578, § 1. Amended by Acts 1985, No. 985, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1271. Identification of property upon which premium is due

A. Any bill or other notice requiring payment of a premium for a policy of property or casualty insurance which is sent by an insurer to its policyholder shall identify the insured property sufficiently to allow the policyholder to identify the property upon which the premium is due. Such identification may be by description or may be by address if the property is real estate.

B. The provisions of Subsection A of this Section shall not apply to bills for policies which are billed more often than semiannually or to bills for policies which insure multiple properties, locations, or vehicles.

Renumbered from R.S. 22:1478 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 381, § 1.

§§ 1272 to 1280. Reserved for future legislation

SUBPART B. VEHICLE

§ 1281. 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.

Renumbered from R.S. 22:622.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 959, § 1.

§ 1282. 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, or express or implied permissive users, 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.

Renumbered from R.S. 22:622.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1071, § 1. Amended by Acts 2004, No. 395, § 1; Acts 2005, No. 418, § 1; Acts 2009, No. 280, § 1.

§ 1283. Proof of motorcycle endorsement

A. Each person who makes an application for issuance of a policy of insurance

covering a motorcycle shall provide proof of the appropriate license endorsement required by R.S. 32:408(C). Such proof shall be provided to the insurer or its producer within ninety days of application for such policy. If the policy of insurance is issued by an insurer that does not maintain an office in this state, then the person may submit a sworn affidavit that he has the proper license endorsement to the insurer.

B. In the case of an initial application for the endorsement, the insurer may issue a policy not to extend more than ninety days.

C. In addition to any other applicable penalties, anyone in violation of this Section shall be subject to a fine of no more than five hundred dollars.

Renumbered from R.S. 22:622.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 40, § 1. Amended by Acts 2004, No. 378, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2013, No. 101, § 1.

§ 1284. 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 attorney 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.

Renumbered from R.S. 22:1466 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 578, § 1. Amended by Acts 1992, No. 525, § 1; Acts 1992, No. 832, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1284.1. Motor vehicle insurance; consideration of lapse in coverage prohibited

A. No insurer shall increase the premium rate or increase or add a surcharge on any policy of motor vehicle insurance when such action is based solely on consideration of a lapse in coverage, as defined in this Section, regarding the insured as provided in this Section.

B. As used in this Section, a "lapse in coverage" is that period of time during

which the owner of a motor vehicle who formerly maintained liability coverage on a vehicle, as required under the Motor Vehicle Safety Responsibility Law, first voluntarily surrenders the vehicle's license plate to the office of motor vehicles and then ceases to maintain a policy of insurance or other security as required by the Motor Vehicle Safety Responsibility Law.

C. Any insurer who violates the provisions of this Section shall refund to the insured person the amount of premium which was paid that exceeded the amount of premium which would have been charged if the insurer had complied with this Section. The commissioner of insurance shall promulgate rules and regulations to enforce the provisions of this Section.

D. Notwithstanding any other provisions of law to the contrary, one or more lapses in coverage, as defined in this Section, shall not be the sole basis for an insurer's denial of an application for a policy of motor vehicle insurance nor shall such lapse in coverage 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 a lapse in coverage.

Added by Acts 2010, No. 636, § 1.

§ 1285. 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 of the Louisiana Department of Public Safety and Corrections.

Renumbered from R.S. 22:635.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 331, § 1. Amended by Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1286. 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.

Renumbered from R.S. 22:635.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 205, § 1.

§ 1287. Overpayments; surplus premium; endorsement credits

All automobile insurers shall as soon as reasonably possible, but in no event later than sixty 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 sixty-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. However, when the insured continues to maintain

a policy of insurance with the insurer, or an affiliated insurer, and the amount of the refund plus interest is twenty-five dollars or less, the insurer may credit the amount of the payment against future premiums. The insurer shall give written notice to the insured of the credit and the amount at policy renewal.

Renumbered from R.S. 22:636.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1428, § 1. Amended by Acts 2012, No. 55, § 1.

§ 1288. 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 of the Department of Public Safety and Corrections.

B. Where the owner of the covered vehicle has a physical or mental disability 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.

Renumbered from R.S. 22:652.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1982, No. 285, § 1. Amended by Acts 1993, No. 552, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2014, No. 811, § 11, eff. June 23, 2014.

§ 1289. 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.

Renumbered from R.S. 22:1472 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 41, § 1. Amended by Acts 1995, No. 1098, § 1.

§ 1289.1. Automobile insurance policies; policy issuance based upon impending weather conditions

No insurer shall refuse to issue an automobile insurance policy providing collision or comprehensive coverage on a newly purchased motor vehicle, at the time of purchase of the automobile from a duly licensed motor vehicle dealer, to one of the insurer's existing automobile policyholders who is an otherwise qualified purchaser, based solely upon a named tropical storm or hurricane in the Gulf of Mexico.

Added by Acts 2009, No. 324, § 1.

§ 1290. Motor vehicle liability policy

No settlement made under a vehicle liability insurance policy for 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.

Renumbered from R.S. 22:661 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 348, § 1. Amended by Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1291. 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.

Renumbered from R.S. 22:671 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 756, § 1. Amended by Acts 1997, No. 1060, § 1.

§ 1292. Towing and storage of motor vehicles; insurance policies; storage fees; exceptions

A. A motor vehicle 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 a motor vehicle 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. Repealed by Acts 2006, No. 628, § 2.

Renumbered from R.S. 22:672 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 951, § 1. Amended by Acts 1992, No. 375, § 1; Acts 1999, No. 1108, § 1; Acts 2006, No. 628, § 1.

§ 1293. 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 airbags.

Renumbered from R.S. 22:676 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2005, No. 262, § 1.

§ 1294. 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.

Renumbered from R.S. 22:1465 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 944, § 1. Amended by Acts 1992, No. 868, § 1.

§ 1295. 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 in this Section. 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 [Repealed], 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) 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 such 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 with respect to bodily injury to an injured party while occupying an automobile not owned by said injured party, resident spouse, or resident relative, and the following priorities of recovery under uninsured motorist coverage shall apply:

(i) The uninsured motorist coverage on the vehicle in which the injured party was an occupant is primary.

(ii) 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 the minimum amount of property damage liability insurance required by the Motor Vehicle Safety Responsibility Law, R.S. 32:851 et seq., 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 the resulting death of an insured, 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 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; however, the submission to arbitration shall be optional with the insured, shall not deprive the insured 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 Subparagraphs (a), (b), and (c) of this Paragraph 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.

Renumbered from R.S. 22:680 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:1406(D) by Acts 2003, No. 456, § 3. Amended by Acts 1962, No. 187, § 1; Acts 1964, No. 118, § 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 1977, No. 438, § 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, eff. Sept. 9, 1988; Acts 1988, No. 233, § 1, eff. July 6, 1988; Acts 1990, No. 301, § 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 1997, No. 1476, § 3, eff. Sept. 6, 1998; Acts 1999, No. 732, § 1; Acts 2003, No. 456, § 1; Acts 2008, No. 194, § 1; Acts 2010, No. 210, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1295.1. Excluded driver; named insured; liability

A. The named insured and the operator of a motor vehicle shall be solidarily liable for the damages caused by the operator's negligent or intentional act when the operator has been designated as a person excluded from coverage on the motor vehicle liability insurance policy pursuant to R.S. 32:900(L), and the operator is operating the vehicle with the express permission of the named insured.

B. The liability of the named insured provided by this Section shall not exceed the mandatory minimum limits for automobile insurance as provided by R.S. 32:900, unless the named insured has a parent-child or tutorship relationship to the operator, or unless the named insured is otherwise vicariously liable for the acts or omissions of the operator excluded from coverage on the motor vehicle liability insurance policy pursuant to R.S. 32:900(L) or unless the named insured is responsible for the acts and omissions of the operator excluded from coverage on the motor vehicle liability insurance policy pursuant to R.S. 32:900(L).

C. If the operator has been excluded pursuant to R.S. 32:900(L), the insurer shall not be liable, and no liability or obligation of any kind shall result to the insurer for bodily injury, loss, or damage under any coverage of the policy, nor shall the insurer be obligated to provide a defense or pay any costs of defense.

Added by Acts 2014, No. 21, § 1.

§ 1296. Coverage of temporary, substitute, and rental vehicles

A. 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 motor vehicles any and all such insurance coverage in effect in the original policy or policies. Where an insured has coverage on a single or

multiple vehicles, at least one of which has comprehensive and collision or liability insurance coverage, those coverages shall apply to the temporary substitute motor vehicle, as defined in the applicable insurance policy, or rental motor vehicle. Such insurance shall be primary. However, if other automobile insurance coverage or financial responsibility protection 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.

B. A rental company, as defined in R.S. 22:1762(5), shall maintain security on all rental vehicles meeting the requirements of the Motor Vehicle Safety Responsibility Law, R.S. 32:851 et seq., as follows:

(1) Such security maintained by the rental company shall apply only when there is no other valid or collectible insurance or other form of security meeting the minimum financial responsibility requirements under the Motor Vehicle Safety Responsibility Law.

(2) Notwithstanding a rental company's obligation to provide minimum financial responsibility pursuant to the Motor Vehicle Safety Responsibility Law as the owner of the vehicle for the privilege of registering and titling such vehicle, a rental company shall be relieved of any security obligation under the Motor Vehicle Safety Responsibility Law when the renter or driver has valid and collectible insurance, self-insurance, bond, deposit, or other form of security in an amount sufficient to satisfy the minimum financial responsibility requirements of the Motor Vehicle Safety Responsibility Law, when the claimant maintains uninsured or underinsured motorist coverage for bodily injury or property damage claims, or when the renter violates the terms or conditions of the rental agreement.

(3) Nothing in this Section shall be construed:

(a) To limit or restrict a rental company from providing by contract that the renter or driver shall assume responsibility for satisfying any and all duties and obligations for claims under the Motor Vehicle Safety Responsibility Law provided that the renter or driver has valid and collectible insurance, self-insurance, bond, deposit, or other form of security, which financial responsibility protection provided to the renter or driver shall be primary.

(b) To limit the ability of a rental company to pursue the renter or driver of the rental vehicle for indemnity or contribution or both.

(c) To create an obligation by the rental company to defend renters or drivers of rental vehicles.

(d) To render a rental company subject to R.S. 22:1269, 1892, or 1973.

(4) In the event that the rental company provides minimum financial responsibility limits pursuant to this Section, the rental company shall be exempt from R.S. 22:1295 and shall not be required to extend uninsured or underinsured motorist coverage or to offer renters or additional authorized drivers an opportunity to accept, reject, or select lower limits of uninsured or underinsured motorist coverage.

Renumbered from R.S. 22:681 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:1406(F) by Acts 2003, No. 456, § 3. Amended by Acts 1989, No. 438, § 1; Acts 1997, No. 951, § 1; Acts 2007, No. 354, § 1.

§ 1297. 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.

Renumbered from R.S. 22:673 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 867, § 1.

SUBPART C. FIRE AND EXTENDED COVERAGE (STANDARD FIRE POLICY)

§ 1311. Fire insurance contract; standard provisions; variations

A. The printed form of a policy of fire insurance, as set forth in Subsection F of this Section, shall be known and designated as the "standard fire insurance policy of the State of Louisiana."

B. (1) No policy or contract of fire insurance shall be made, issued, or delivered by any insurer, or by any producer or representative thereof, on any property in this state, unless it shall conform as to all provisions, stipulations, agreements, and conditions, as provided in this Subpart.

(2) There shall be printed at the head of the 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.

(3) The standard fire insurance policy provided for herein need not be used for effecting reinsurance between insurers.

(4) If the policy is issued by a mutual, cooperative, 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 commissioner of insurance 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 engage in the business of fire insurance in this state may, with the approval of the commissioner of insurance, issue a combination standard form fire insurance policy which shall contain the following provisions:

(1) A provision 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 commissioner of insurance, be used in connection with a standard fire insurance policy. 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 commissioner, 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)(a) Any policy or contract otherwise subject to the provisions of Subsections A and B of this Section, which includes either 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 of this Section provided each of the following apply: (i) 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; (ii) the provisions in relation to mortgagee interests and obligations in said standard fire policy may be incorporated therein without change; (iii) 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 (iv) the commissioner is satisfied that such policy or contract complies with the provisions hereof.

(b) 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 _____ 20___, to the _____ day of _____ 20___, 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 _____, 20___.

_____

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 ensues, 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- day written notice of cancellation, or ten-day 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-day written notice of cancellation, or a ten-day 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 to do so 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 first-party 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 twenty-four 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 Subpart 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.

Renumbered from R.S. 22:691 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2007, No. 43, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1312. Forms to be provided

Upon receiving notice of loss from the insured, the insurer shall provide 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 to submit a proof of loss.

Renumbered from R.S. 22:691.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1977, No. 202, § 1. Amended by Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1313. Fire insurance contract; standard provisions; variations

A. Notwithstanding the requirements of R.S. 22:1311 concerning the use of the standard fire policy provisions, 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.

C. Failure to attach the standard fire policy as provided in R.S. 22:1313(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.

Renumbered from R.S. 22:691.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 133, § 1, eff. June 26, 1986. Amended by Acts 2004, No. 34, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1314. Breach of warranties and conditions of fire policies and applications therefor

A. 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 such policy or in the application therefor. Such breach shall not allow the insurer to avoid liability unless such breach: (1) exists at the time of the loss, and be 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.

B. Notwithstanding the provisions of Subsection A of this Section, such a breach shall not afford a defense to a suit on the policy if the 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 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.

Renumbered from R.S. 22:692 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1315. 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. Such judicial determination shall apply to the claim that is the subject of the litigation and shall not apply retroactively to any claim that occurred prior to the loss that is the basis of the claim that is the subject of the litigation.

Renumbered from R.S. 22:692.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1985, No. 506, § 1. Amended by Acts 2007, No. 156, § 1, eff. June 25, 2007.

§ 1316. 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.

Renumbered from R.S. 22:693 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 1317. Co-insurance clauses; prohibited in certain cases

No policy of fire and extended coverage insurance issued by an authorized insurer 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 commissioner of insurance and there has been a consideration allowed in the rate of premium charged for such policy.

Renumbered from R.S. 22:694 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 330, § 1; Acts 1963, No. 115, § 1; Acts 2009, No. 250, § 1.

§ 1318. 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 apply only to policies issued or renewed after January 1, 1992, and shall not apply to a loss covered by a blanket-form policy of insurance. As used in this Section, the term "fire insurance policy" shall mean any property insurance policy, with the exception of builders risk policies of insurance, that provides coverage for the peril of fire, regardless of any other coverage provided by the policy.

Renumbered from R.S. 22:695 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 850, § 1. Amended by Acts 1995, No. 737, § 1; Acts 2014, No. 91, § 1.

§ 1319. Delivery of fire insurance contract providing coverage for damage to property; disclosure of coverage; coverage for damages due to flood

A. In addition to any other requirement contained in law, the following provisions shall govern the issuance of fire insurance policies issued or delivered in this state which provide coverage for damage to property in this state.

B. No fire insurance policy which provides coverage for damage to property shall be delivered or issued for delivery in this state unless the insurer advises the insured in writing, prominently displayed on a form developed and promulgated by the commissioner of insurance and in bold typed print of not less than a fourteen-point font as an insert in the front of the policy, of the following disclosures:

(1) Which coverages are included in the policy for which the insured has paid premiums.

(2) Whether or not the insured has coverage for flooding or mold. The disclosure shall also state that flood insurance is available through the National Flood Insurance Program and that excess flood insurance may be available by a separate policy.

(3) Whether a separate deductible is required for hurricane, wind, or named-storm damage, and, if so, one standardized example of how such separate deductible will be applied under the policy. Such example need not be customized for each policyholder.

C. Any disclosure provided pursuant to this Section shall be for informational purposes only and shall not amend, extend, or alter the coverages provided in the policy. In addition, any such notice shall not be admissible in any action brought concerning the policy of insurance except for the sole purpose of showing that the notice was or was not provided pursuant to this Section.

Renumbered from R.S. 22:696 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2005, 1st Ex.Sess., No. 38, § 1, eff. Dec. 6, 2005. Amended by Acts 2006, 1st Ex.Sess., No. 42, § 1; Acts 2009, No. 36, § 1, eff. Jan. 1, 2010.

§ 1320. Prohibition of denial of coverage

Notwithstanding anything to the contrary, liability coverage, which would otherwise be valid under the terms of the policy, shall not be declared void under any contract provision which specifically denies coverage for any and all acts committed due to criminal conduct, where such criminal conduct is due to the criminally negligent ownership or handling of a dog or other animal pursuant to R.S. 14:32(A)(2) or R.S. 14:39(A)(2).

Added by Acts 2009, No. 199, § 3.

SUBPART D. HOMEOWNERS' INSURANCE

§ 1331. Personal property coverage; option to exclude

A. In the gubernatorially declared disaster areas for Hurricanes Katrina and Rita, any insurance company that issues a homeowner's policy as is defined in R.S. 22:47(15) and which includes personal property coverage in the coastal parishes of Louisiana, except for rental insurance, shall make available, during the term of the policy, upon written request of the policyholder one of the following options: (1) a residential property policy that provides dwelling coverage without personal property coverage or (2) an exclusion of personal property coverage that shall be accompanied by an appropriate reduction in premium that shall be returned to the policyholder.

B. Notwithstanding any provision of law to the contrary, such substitute policy or exclusion of personal property coverage that occurs during the term of the policy shall not be considered a new policy. This Section shall only apply to homeowners' insurance policies written on structures that have been rendered uninhabitable by Hurricanes Katrina and Rita because they have sustained extensive damage to more than fifty percent of the dwelling area. In addition, the insurer may withdraw the exclusion or substitute policy after the structure has been repaired to the point that it is again habitable or the homeowners' policy has been terminated.

Renumbered from R.S. 22:667.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 449, § 1, eff. July 20, 2007; Acts 2007, No. 449, § 1, eff. Aug. 15, 2007. Amended by Acts 2008, No. 125, § 1.

§ 1332. Delivery of homeowners' insurance; disclosures

A. In addition to any other requirement contained in law, the provisions of this Section shall govern the issuance of homeowners' insurance policies issued or delivered in this state which provide coverage for damage to property in this

state.

B. No homeowners' insurance policy which provides coverage for damage to property shall be delivered or issued for delivery in this state with respect to any residential property unless the insurer advises the insured in writing, prominently displayed on a form developed and promulgated by the commissioner of insurance and in bold typed print of not less than a fourteen-point font as an insert in the front of the policy, of the following disclosures:

(1) Which coverages are included in the policy for which the insured has paid premiums.

(2) Whether or not the insured has coverage for flood or mold. The disclosure shall also state that flood insurance is available through the National Flood Insurance Program and that excess flood insurance may be available by a separate policy.

(3) A distinction between replacement cost for losses and actual cash value, the use of depreciation in determining payment for losses, and that the policy may contain time limitations for repairs to be completed in order to receive full replacement cost for the losses.

(4) That the policy determines the process for providing the insurer with a notification of a loss, and the time line provided by law, including R.S. 22:1892 and 1973, of when a claim must be adjusted, settled, and paid, including an explanation of the possible penalties imposed on an insurer for failing to conform to the time requirements.

(5) That the insured may have the option to increase the deductible and thus lower the potential cost paid.

(6) Whether a separate deductible is required for hurricane, wind, or named-storm damage, and, if so, one standardized example of how such separate deductible will be applied under the policy. Such example need not be customized for each policyholder.

C. Any disclosure provided pursuant to this Section shall be for informational purposes only and shall not amend, extend, or alter the coverages provided in the policy. In addition, any such notice shall not be admissible in any action brought concerning the policy of insurance except for the sole purpose of showing that the notice was or was not provided pursuant to this Section.

Renumbered from R.S. 22:1477 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 42, § 1. Amended by Acts 2006, No. 438, § 1; Acts 2009, No. 36, § 1, eff. Jan. 1, 2010.

§ 1333. Homeowner's insurance; insurer's nonrenewal without cause; inclusion in insured's file prohibited; certain prohibitions

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 or premium 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.

(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 continuous three-year period of time within the five years preceding the current policy renewal date, or if continuation of such policy endangers the solvency of the insurer. This Subsection shall not apply to an insurer that withdraws from the homeowners' insurance market in this state or to policy deductibles increased for all homeowners' insurance policies in this 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. As used in this Subsection, the phrase "two or more claims within a continuous three-year period of time within the five years preceding the current policy renewal date" shall not include any loss incurred or arising from an "Act of God" incident which is due directly to forces of nature and exclusively without human intervention.

D. Notwithstanding the provisions of Subsection C of this Section, an insurer may make a filing with the commissioner pursuant to R.S. 22:1464 for authorization to deviate from the provisions of Subsection C of this Section for the sole purpose of changing the policy deductible to a total deductible of not more than four percent of the value of the property being insured for named storms or hurricanes on a homeowner's policy of insurance that has been in effect for more than three years. Any insurer filing with the commissioner pursuant to this Subsection shall file with the commissioner a business plan setting forth the insurer's plan to write new business in the particular region or area of the state in which the new deductible is to apply. The commissioner's approval is to be based on the insurer's commitment to the writing of new business in the respective region or area of the state in which the new deductible is to apply. The commissioner may also approve a filing that he determines to be in the best interest of the policyholders. The commissioner may subsequently rescind his approval of any filing made pursuant to this Subsection in the event the insurer fails to write new business in accordance with the business plan. Any business plan filed shall be considered proprietary or trade secret pursuant to information under the provisions of R.S. 44:3.2 and the Uniform Trade Secrets Act. The commissioner shall provide an annual report to the legislative committees on insurance on the application and effectiveness of the provisions of this Section. The commissioner shall promulgate regulations pursuant to the Administrative

Procedure Act setting forth the criteria for the filing, including any financial or other requirements that he deems necessary to act on the request by an insurer. Any regulation promulgated by the commissioner pursuant to this Subsection shall require the insurer to itemize to the insured the premium savings based on the increase in the insured's deductible.

E. No homeowner's policy of insurance shall contain any provision that would apply more than one deductible to a loss resulting from any single incident covered by the policy. Any such provision shall be null and void and unenforceable as contrary to public policy.

F. Any company which makes a filing pursuant to Subsection D of this Section shall reduce the rates paid by the individual homeowner by the amount determined to be actuarially justified by the commissioner.

G. Any authorized property and casualty insurer that avails itself of the provisions of Subsection C of this Section relative to withdrawing from the homeowners' insurance market may not issue any homeowners' insurance coverage in this state during the five-year period beginning on the date of the discontinuation of the last homeowners' insurance coverage not so renewed. The commissioner may, for good cause shown pursuant to a written request by the insurer, permit the insurer to reenter the homeowners' insurance market prior to the expiration of the five-year period.

H. Any approved unauthorized property and casualty insurer that avails itself of the provisions of Subsection C of this Section relative to withdrawing from the homeowners' insurance market may not issue any homeowners' insurance coverage in this state during the five-year period beginning on the date of the discontinuation of the last homeowners' insurance coverage not so renewed. The commissioner may, for good cause shown pursuant to a written request by the insurer, permit the insurer to reenter the homeowners' insurance market prior to the expiration of the five-year period.

Renumbered from R.S. 22:635.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Redesignated from R.S. 22:1405.1 by Acts 2003, No. 456, § 3. Amended by Acts 2007, No. 381, § 1, eff. July 10, 2007; Acts 2008, No. 854, § 1, eff. July 9, 2008; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2014, No. 353, § 1.

§ 1334. 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 O of Part IV of Chapter 4 of this Title, R.S. 22:1451 et seq.

Renumbered from R.S. 22:635.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 358, § 1. Amended by Acts 2005, No. 258, § 1.

§ 1335. 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.

Renumbered from R.S. 22:636.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 774, § 1.

§ 1336. 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.

Renumbered from R.S. 22:1471 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 70, § 1.

§ 1337. Homeowners' insurance deductibles applied to named-storms, hurricanes, and wind and hail deductibles

A. For purposes of this Section, the following definitions shall apply:

(1) "Hurricane" means a storm system that has been declared a hurricane by the National Hurricane Center of the National Weather Service.

(2) "Named storm" means a storm system that has been declared a named storm by the National Hurricane Center of the National Weather Service.

(3) "Separate deductible" means a deductible that applies to damage incurred during a specified weather event and may be expressed as a percentage of the insured value of the property or as a specific dollar amount and includes hurricane, named-storm, and wind and hail deductibles.

B. For all homeowners' insurance policies or other policies insuring a one- or two-family owner occupied premises for fire and allied lines, issued or renewed by authorized insurers on or after January 1, 2010, any separate deductible that applies in place of any other deductible to loss or damage resulting from a named storm or hurricane shall be applied on an annual basis to all named-storm or hurricane losses that are subject to the separate deductible during the calendar year.

C. If an insured incurs named-storm or hurricane losses from more than one named storm or hurricane during a calendar year that are subject to the separate deductible referred to in Subsection B of this Section, the insurer may apply a deductible to the succeeding named storms or hurricanes that is equal to the remaining amount of the separate deductible, or the amount of the deductible that applies to all perils other than a named storm or hurricane, whichever is greater. Insurers may require policyholders to maintain receipts or other records of such losses in order to apply such losses to subsequent named-storm or hurricane claims.

Added by Acts 2009, No. 134, § 1, eff. June 25, 2009.

§ 1338. Homeowners' insurance; prohibited actions involving Chinese drywall; penalty

A. No insurer shall cancel or fail to renew any homeowners' insurance policy, regardless of whether the policy has been in effect for less than three years, based solely on the presence of installed Chinese drywall in the insured's property or the filing of a claim by an insured that is based on the presence of Chinese drywall which, prior to December 31, 2009, was imported from, or manufactured in, the People's Republic of China. Nothing in this Section shall be construed to allow an insured to avoid its obligations under the terms of the insurance contract.

B. Any insurer violating the provisions of this Section shall be subject to a penalty to be imposed by the commissioner which penalty shall be up to fifteen thousand dollars, plus all attorney fees, expenses, and court costs incurred by the homeowner in having the policy reinstated.

C. Any insurer which has canceled or failed to renew a policy after an insured has made a claim due to the presence of Chinese drywall shall have thirty days from the effective date of this Section to reinstate the policy on the same terms and conditions that applied to the policy prior to the claim or be in violation of the provisions of this Section.

D. This Section shall not amend, alter, or affect binders, as defined in R.S. 22:870, that are used to bind insurance coverage temporarily pending the issuance of an insurance policy.

E. The provisions of this Section shall cease to be effective after July 1, 2013.

Added by Acts 2010, No. 1005, § 1, eff. July 8, 2010.

SUBPART E. BURGLARY AND FORGERY INSURANCE

§ 1351. [Reserved]

SUBPART F. GLASS POLICIES

§ 1361. [Reserved]

SUBPART G. CROP AND LIVESTOCK INSURANCE

§ 1371. [Reserved]

SUBPART H. MARINE AND TRANSPORTATION (INLAND MARINE) INSURANCE

§ 1381. [Reserved]

SUBPART I. STEAM BOILER AND SPRINKLER LEAKAGE INSURANCE

§ 1391. [Reserved]

SUBPART J. LIABILITY

§ 1401. [Reserved]

SUBPART K. CREDIT PROPERTY AND CASUALTY

§ 1411. [Reserved]

SUBPART L. WORKERS' COMPENSATION INSURANCE

§ 1421. [Reserved]

SUBPART M. MISCELLANEOUS INSURANCE

§ 1431. Portable electronics insurance policies

A. Portable electronics insurance as defined in R.S. 22:1781.1 may be offered on a month-to-month or other periodic basis as a group or master commercial insurance policy issued to a vendor, as defined in R.S. 22:1781.1 of portable electronics for its enrolled customers.

B. Notwithstanding any other provision of law to the contrary, an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty days' written notice.

C. If the insurer changes the terms and conditions of a policy, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of any material change.

D. Notwithstanding Subsection B of this Section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen days' written notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

E. Notwithstanding Subsection B of this Section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(1) For nonpayment of premium.

(2) If the enrolled customer ceases to have an active service with the vendor of portable electronics.

(3) If the enrolled customer exceeds the aggregate limit of liability under the terms of the portable electronics insurance policy.

F. If an enrolled customer exhausts the aggregate limit of liability under the terms of the portable electronics insurance policy, the insurer shall send notice of termination to the enrolled customer within thirty calendar days after exhaustion of the limit. If notice is not timely sent, coverage shall continue notwithstanding the exhaustion of the aggregate limit of liability, until the insurer sends notice of termination to the enrolled customer.

G. Where a portable electronics insurance policy is terminated by a vendor, the vendor shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty days prior to the termination.

H. All notices or correspondence required by this Section or otherwise required by law shall be in writing. Notices and correspondence may be sent either by mail or by electronic means as set forth in this Section. If the notice or correspondence is mailed, it shall be sent to the vendor or the enrolled customer at the mailing address on file with the insurer or vendor. The insurer or vendor of portable electronics shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent electronically, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last known electronic mail addresses as provided by each enrolled customer to the insurer or vendor of portable electronics. For purposes of this Section, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, shall maintain proof that the notice or correspondence was sent.

I. Notice or correspondence required by this Section or otherwise required by law may be sent on behalf of an insurer or vendor by a person licensed as an insurance producer in this state or any other person with whom the insurer or vendor contracts to perform such services on their behalf.

Added by Acts 2012, No. 311, § 1.

SUBPART N. FIDELITY AND SURETY INSURANCE

§ 1441. 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) Notice pursuant to Code of Criminal Procedure Article 349.3 has been mailed.

(3) No suspensive appeal has been taken.

(4) The defendant has neither been surrendered nor appeared within one hundred eighty days of mailing of the notice of the signing of the judgment of bond forfeiture.

(5) More than one hundred eighty days has lapsed from the mailing of the 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) Within thirty days of the filing of a rule to show cause by the prosecuting attorney with the commissioner of insurance, the commissioner of insurance shall notify the insurance company, the commercial surety, or Lloyd's Association, in writing, at the address of the home office of that organization by certified mail, setting a time, place, and date of the hearing, which shall not be more than sixty days from the date of receipt of notice from the prosecuting attorney. If after the hearing, the hearing officer finds that there is no just cause or legal reason for the surety's nonpayment, the commissioner shall take any action deemed necessary for collection of the amount owed, including suspension of the surety from doing business in the state of Louisiana.

(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) Notice pursuant to Code of Criminal Procedure Article 349.3 has been mailed.

(c) No suspensive appeal has been taken.

(d) The defendant has neither been surrendered nor appeared within one hundred eighty days of mailing of the notice of the signing of the judgment of bond forfeiture.

(e) More than one hundred eighty days has lapsed from the mailing of the 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 Code of Criminal Procedure Article 349.3 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.

Renumbered from R.S. 22:658.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 834, § 5, eff. June 22, 1993. Amended by Acts 1999, No. 1151, § 1, eff. July 9, 1999; Acts 2010, No. 914, § 4.

§ 1442. Repealed by Acts 2010, No. 162, § 2

§ 1443. 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 rates set by the insurance commissioner, 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 one hundred twenty 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.

Renumbered from R.S. 22:1404.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 834, § 5, eff. June 22, 1993. Amended by Acts 1999, No. 135, § 1; Acts 1999, No. 717, § 2; Acts 2010, No. 162, § 1.

SUBPART O. RATE MAKING PROCEDURES AND ORGANIZATIONS

§ 1451. Systems for ratemaking

A. As used in this Subpart, the term "commissioner" shall mean the commissioner of insurance.

B. The commissioner shall have the exclusive authority to accept, review, and approve any application for insurance rates or rate changes for all lines of property and casualty insurance. The commissioner shall exercise his authority in accordance with the provisions of this Section.

C. (1) Subject to the exception specified in Subsection D of this Section, each filing submitted to the commissioner 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 commissioner may authorize a filing which he has reviewed to become effective before the expiration of the waiting period. A filing shall be deemed to meet the requirements of this Subpart unless disapproved in writing by the commissioner within the forty-five-day waiting period. The commissioner may by rule, regulation, or order reduce or eliminate the waiting

period specified in this Subsection. For any filing that is disapproved, the insurer may appeal such disapproval to the Nineteenth Judicial District Court within fifteen days from the receipt of written notice of disapproval.

(2) Unless notified by the commissioner that a filing is incomplete, or that the filing is disapproved pursuant to this Subpart, the insurer or rating organization may commence use of the filed rates upon expiration of forty-five days from the date of receipt by the commissioner.

D. 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 commissioner for informational purposes only. The commissioner may by rule, regulation, or order reduce or eliminate the annual premium threshold for those entities that enables rate filings to be made under this Subsection.

E. All provisions of this Section shall be applicable when a competitive market in property and casualty lines insurance exists. The commissioner may determine if there exists a competitive or noncompetitive market pursuant to the provisions of R.S. 22:1453, including requiring reasonable notice and a public hearing prior to determining a market to be noncompetitive. If, after a public hearing, the commissioner determines the market to be noncompetitive, all rate filings shall follow the provisions of Subsection C of this Section without regard to the exception specified in Subsection D of this Section. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

F. No provision of this Section shall prohibit the commissioner from conducting market conduct exams to ensure the rates being charged by insurers are not inadequate, excessive, or unfairly discriminatory.

Renumbered from R.S. 22:1401 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1960, No. 296, § 1. Amended by 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; Acts 2003, No. 351, § 1, eff. Jan. 1, 2004; Acts 2003, No. 456, § 1; Acts 2003, No. 774, § 5; Acts 2004, No. 878, § 1, eff. Jan. 1, 2005; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2009, No. 317, § 1.

§ 1452. Purpose of rate regulation; construction; definitions

A. The purpose of this Subpart 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 ratemaking and in other matters within the scope of this Subpart. Nothing in this Subpart is intended:

(1) To prohibit or discourage reasonable competition.

(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.

B. This Subpart shall be liberally interpreted to carry into effect the provisions of this Section.

C. As used in this Subpart, the following definitions shall be applicable:

(1) "Advisory organization" means any entity or organization which has five unrelated members and which assists insurers as authorized by R.S. 22:1471. It does not include joint underwriting organizations, actuarial or legal consultants, single insurers, any employees of an insurer, or insurers under common control or common management of their employees or managers.

(2) "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

(3) "Commercial risk" means any kind of risk which is not a personal risk.

(4) "Competitive market" means any market except those which have been found to be noncompetitive pursuant to R.S. 22:1453.

(5) "Developed losses" means losses adjusted, including loss adjustment expenses, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss payments, including loss adjustment expenses.

(6) "Excessive" means a rate that is likely to produce a long-term profit that is unreasonably high for the insurance provided. No rate in a competitive market shall be considered excessive.

(7) "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees and does not include loss adjustment expenses.

(8) "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

(9) "Inadequate" means a rate which is unreasonably low for the insurance provided and either the continued use of which endangers the solvency of the insurer using it or will have the effect of substantially lessening competition or creating a monopoly in any market.

(10) "Joint underwriting" means an arrangement established to provide insurance coverage for a risk, pursuant to which two or more insurers contract with the insured for a price and policy terms agreed upon between or among the insurers.

(11) "Large commercial policyholder" means a commercial policyholder with the size, sophistication, and insurance buying expertise to negotiate with insurers in a largely unregulated environment, as further prescribed by the commissioner

by regulation.

(12) "Line of insurance" means those lines identified in this Title or as otherwise specified by the commissioner.

(13) "Loss adjustment expense" means the expense incurred by the insurer in the course of settling and paying claims.

(14) "Market" means the interaction between buyers and sellers in the procurement of a line of insurance pursuant to the provisions of this Subpart.

(15) "Noncompetitive market" means a market which is subject to a ruling pursuant to R.S. 22:1453 that a reasonable degree of competition does not exist. Residual markets and pools are noncompetitive markets for purposes of this Subpart.

(16) "Personal risk" means homeowners, tenants, nonfleet private passenger motor vehicles, mobile homes, and other property and casualty insurance for personal, family, or household needs, including any property and casualty insurance that is otherwise intended for noncommercial coverage.

(17) "Pool" means an arrangement pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. A pool may operate as an association, syndicate, or in any other generally recognized manner.

(18) "Prospective loss cost" means that portion of a rate that does not include provisions for expenses or profit and is based on historical aggregate losses adjusted through development to their ultimate value, projected through trending to a future point in time, and adjusted for other considerations expected to materially affect future loss payments.

(19) "Rate" means that cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, with an adjustment to account for the treatment of loss adjustment expenses, expenses, profit, and variation in expected future loss experience, prior to any application of individual risk variations based on actual past loss or expense considerations, and does not include minimum premiums.

(20) "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment of risks among insurers for insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

(21) "Special assessments" means guaranty fund assessments, special indemnity fund assessments, vocational rehabilitation fund assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

(22) "Supplementary rate information" means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, and any other similar information needed to determine an applicable rate in effect or to be in effect.

(23) "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the

filer, the interpretation of any statistical data relied upon by the filer, descriptions of methods used in making the rates, and other similar information relied upon by the filer.

(24) "Trending" means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

(25) "Unfairly discriminatory" means not capable of being actuarially justified or based on race, color, creed, or national origin. It does not refer to rates that produce differences in premiums for policyholders with different loss exposures, so long as the rate is actuarially justified and reflects such differences with reasonable accuracy.

Renumbered from R.S. 22:1402 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1960, No. 296, § 1. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1453. Competitive market

A. (1) A competitive market for a line of insurance is presumed to exist unless the commissioner, after giving reasonable notice and after conducting a public hearing, determines that a reasonable degree of competition does not exist within a market and issues a ruling that a reasonable degree of competition in the market for a particular line of insurance does not exist. In any public hearing to determine whether a competitive market exists for a line of insurance, the party alleging that competition does not exist shall have the burden of proving that market competition does not exist.

(2) If the commissioner issues a ruling pursuant to this Section that a competitive market does not exist for a line of insurance, the ruling shall identify those factors listed in Subsection B of this Section that have caused the market to be noncompetitive and shall describe the action or actions to be undertaken by the commissioner and the state to return competition to the market.

(3) Each ruling that a market is not competitive shall expire one year from the date of issuance unless rescinded by the commissioner prior to such date or renewed by the commissioner pursuant to this Subsection.

(4) The commissioner may renew a ruling that a market is not competitive if, after conducting a public hearing on such renewal, the commissioner determines that a continued lack of reasonable competition exists in the market for a line of insurance. The action to renew a finding of no competition under this Subsection shall state the actions undertaken by the commissioner and the state to restore competition and the reasons such actions failed to return competition to the market.

B. The following factors shall be considered by the commissioner in determining if a reasonable degree of competition exists in a particular line of insurance:

(1) The number of insurers or groups of affiliated insurers providing coverage in the market.

(2) Measures of market concentration and changes of market concentration over time.

(3) Ease of entry into the market and the existence of financial or economic barriers preventing new insurers from entering the market.

(4) The extent to which any insurer or group of affiliated insurers controls all or a portion of the market.

(5) Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options.

(6) The availability of insurance coverage to consumers in the market.

(7) The opportunities available to consumers in the market to acquire pricing and other consumer information.

C. The commissioner shall regularly monitor the degree and existence of competition in the state. The commissioner may utilize existing relevant information, analytical systems, and other sources, or any combination of such items. These monitoring activities may be conducted within the Department of Insurance, in cooperation with other state insurance regulators, through outside contractors, or in any other appropriate manner.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1402.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008. Amended by Acts 2009, No. 317, § 1.

§ 1454. Rating standards and methods

A. Rates shall not be inadequate or unfairly discriminatory in a competitive market. Rates shall not be excessive, inadequate, or unfairly discriminatory in a noncompetitive market. Risks may be classified using any criteria except that no risk shall be classified on the basis of race, color, creed, or national origin.

B. In determining whether rates are excessive, inadequate, or unfairly discriminatory, consideration may be given to the following items:

(1) Basic rate factors. Due consideration shall be given to past and prospective loss and expense experience within and outside the state, catastrophe hazards and contingencies, events, or trends within and outside the state, dividends or savings to policyholders, members, or subscribers, and all other relevant factors and judgments. Fines and penalties against an insurer, whether levied by a court or regulatory body, shall not be used by the insurer or considered in any manner in the loss or expense experience for the purpose of setting rates or making rate filings.

(2) Classification. Risks may be grouped by classification for the establishment of rates and minimum premiums. Classification rates may be modified for individual risks in accordance with rating plans or schedules which establish standards for measuring probable variations in hazards or expenses, or both.

(3) Expenses. The expense provisions shall reflect the operating methods of the insurer, the past expense experience of the insurer, and anticipated future expenses.

(4) Contingencies and profits. The rates shall contain a provision for contingencies and a provision for a reasonable underwriting profit and shall reflect investment income directly attributable to unearned premium and loss reserves.

(5) Other relevant factors. Any other factors available at the time of the rate filing.

C. Except as provided by this Subpart, the commissioner shall not approve or otherwise regulate rates.

Renumbered from R.S. 22:1402.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008. Amended by Acts 2008, No. 402, § 1, eff. June 21, 2008.

§ 1455. Rate regulation when market determined to be noncompetitive

A. If the commissioner determines that competition does not exist in a market and issues a noncompetitive ruling pursuant to R.S. 22:1453, the rates applicable to insurance sold in that market shall be regulated in accordance with the provisions of this Subpart applicable to noncompetitive markets.

B. Any rate filing in effect at the time the commissioner determines that competition does not exist shall be deemed to be in compliance with the laws of this state unless disapproved pursuant to the procedures and rating standards contained in this Subpart applicable to noncompetitive markets.

C. Any insurer having a rate filing in effect at the time the commissioner determines that competition does not exist may be required to furnish supporting information within thirty days of a written request by the commissioner.

Renumbered from R.S. 22:1402.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1456. Scope of rate regulation

A. This Subpart applies to fire, marine and transportation, title insurance, and casualty insurance risks or operations in this state.

B. (1) For the purpose of this Subpart, fire insurance includes insurance coverage as defined in R.S. 22:47(10), (11)(b), and (12), and such other coverages as are usually written by fire insurers other than motor vehicle insurance; marine and transportation insurance includes personal floater insurance and the kinds of insurance defined in R.S. 22:47(13) and such other inland marine coverages as may be so established by interpretation, by ruling of the commissioner of insurance, or by general customs of the business; title insurance includes the kind of insurance coverage as defined in R.S. 22:47(9); and casualty insurance includes the kinds of casualty insurance defined in R.S. 22:47(3), (4), (5), and (6), except personal property floater, R.S. 22:47(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 surplus lines 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 Subpart.

C. This Subpart shall not apply:

(1) To reinsurance, other than joint reinsurance to the extent stated in R.S. 22:1472.

(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 workers' 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 Subpart, the provisions of which conflict, an insurer to which such conflicting provisions are otherwise applicable shall file with the commissioner of insurance 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.

Renumbered from R.S. 22:1403 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1960, No. 296, § 1. Amended by Acts 2002, 1st Ex.Sess., No. 160, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2015, No. 193, § 1.

§ 1457. Discounts; rate reductions

A. (1) A rate reduction of up to ten percent shall be authorized by the commissioner, 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.

(2) The form of certification shall be as determined by the commissioner. 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 Public Safety and Corrections, public safety services, 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.

(3) 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 commissioner 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.

B. (1) The provisions of Subsection A of this Section notwithstanding, the commissioner 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.

(2) 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.

(3) 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 commissioner 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.

C. 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 commissioner 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.

D. A rate reduction shall be authorized by the commissioner, 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.

E. A rate reduction shall be authorized by the commissioner, 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 a global positioning system (GPS) or a vehicle tracking system which aids in the recovery of stolen vehicles as such system shall be further defined by rules and regulations promulgated by the Department of Insurance.

F. 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.

G. Any insurer who makes application to the commissioner for a rate filing shall provide in its application details as to what discount or reduced rate will be given to insureds who comply with the State Uniform Construction Code.[1]

Renumbered from R.S. 22:1404 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1960, No. 296, § 1. Amended by 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; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2008, No. 132, § 1, eff. June 6, 2008; Acts 2011, No. 294, § 1.

[1] R.S. 40:1730.21 et seq.

§ 1458. Disclosure of financial condition for determination of rate increase

The commissioner may require any insurer to furnish to him any financial information which he may request concerning the financial condition of the insurer. The commissioner 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.

Renumbered from R.S. 22:1404.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1978, No. 595, § 1. Amended by Acts 1997, No. 649, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1459. Examinations and investigations; subpoena; discovery

While conducting any examination or investigation, under R.S. 22:1458 or otherwise as may be provided by provisions of this Subpart, the commissioner of insurance may obtain testimony or records or other materials under the powers he possesses in R.S. 22:1990 and 1991. The provisions of R.S. 22:1994 shall apply to any testimony, record, or other material obtained under the provisions of this Section.

Renumbered from R.S. 22:1404.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 843, § 1. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1460. 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 commissioner of insurance, except that any such insurer may deviate from such rates in accordance with R.S. 22:1468. 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 commissioner of insurance through a duly licensed company or through a rating organization licensed under R.S. 22:1466.

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 consist of nineteen members, as follows:

(a) One member shall be the commissioner of insurance or his designee.

(b) Three members shall be appointed by the commissioner of insurance, and each appointment shall be subject to confirmation by the Senate.

(c) Repealed by Acts 2007, No. 459, § 3, eff. Jan. 1, 2008.

(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 include representatives of stock and nonstock members with consideration given to the ratio of their direct fire insurance premiums, less returned premiums, for the most recently available calendar year. Such direct fire insurance premiums, less returned premiums, shall be furnished the association by the commissioner of insurance.

(i) One member shall be a representative designated by the Louisiana Fire Chiefs Association.

(j) One member shall be a representative designated by the Louisiana State Firemen's Association.

(3) Each board member shall be entitled to one vote, except that the legislative members serving pursuant to Subparagraphs (2)(f) and (g) 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 state of Louisiana, and branch offices may be established throughout this state.

C. The commissioner of insurance shall review the rates promulgated by the association or other rating organization to determine whether they meet the requirements of this Subpart. Such review shall be made in the same manner and subject to the same procedure as is provided in R.S. 22:1464.

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 allied lines insurance as defined in Paragraph (10) of R.S. 22:47 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 Subpart. However, by and with the approval of the commissioner of insurance, 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 Subpart.

(3) Repealed by Acts 2013, No. 33, § 2.

(4) To survey municipal areas for publication of public fire protection grading.

(5) To file fire insurance rating schedules with the commissioner of insurance.

(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.

(11) To consider the addendum and other recommendations of the advisory committee of the board of directors of the Property Insurance Association of Louisiana in accordance with Subsection M of this Section and to make public the current addendum as approved by the board of directors of the Property Insurance Association of Louisiana.

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, written on properties located in this state by each insurer in the year before the preceding year, provided that any insurer member that 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 the expenses and the fees due by it, within thirty days

after the same is due and payable, the association may refuse to furnish its services to the delinquent and may report such delinquency to the commissioner of insurance, who for such delinquency may suspend or revoke the license of the delinquent member insurer.

F. The association shall be subject to all the provisions of this Subpart governing and regulating other rating organizations hereunder.

G. (1) 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.

(2) Rates for debit fire insurance and allied lines shall be filed directly with the commissioner of insurance and shall be approved and supervised as to both initial filings and requested changes only by the commissioner. 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 Subpart.

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 commissioner of insurance 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 commissioner of insurance 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 commissioner but it shall be not less than one thousand dollars and not more than

five thousand dollars per violation.

(3) All records of the commissioner of insurance 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.

J. A fire chief shall have the right to request a review of the public fire protection grading for his public fire protection area in accordance with R.S. 22:1461 through 1463.

K. The legislative auditor shall have authority to compile financial statements and to examine, audit, or review the books and accounts of the Property Insurance Association of Louisiana and the Louisiana Automobile Insurance Plan. In addition to the authority granted above, the legislative auditor shall have access to and be permitted to examine all paper, books, accounts, records, files, instruments, documents, films, tapes, and any other forms of recordation of the Property Insurance Association of Louisiana and the Louisiana Automobile Insurance Plan, including but not limited to computers and recording devices, and all software and hardware which hold data, are part of the technical processes leading up to the retention of data, or are part of the security system. The legislative auditor shall also have access to and be permitted to examine all paper, books, accounts, records, files, instruments, documents, films, tapes, and any other third-party administrator or contractor, whether public or private, of the Louisiana Citizens Property Insurance Corporation where such information is related to the work performed by the third-party administrator or contractor for the Louisiana Citizens Property Insurance Corporation.

L. The legislative auditor shall have authority to compile financial statements and to examine, audit, or review the books and accounts of the Property Insurance Association of Louisiana and the Louisiana Automobile Insurance Plan. The scope of the examinations may include financial accountability, legal compliance and evaluations of the economy, efficiency, and effectiveness of the private water supply systems or any combination of the foregoing. In addition to the authority granted above, the legislative auditor shall have access to and be permitted to examine all papers, books, accounts, records, files, instruments, documents, films, tapes, and any other forms of recordation of all private water supply systems, including but not limited to computers and recording devices, and all software and hardware which hold data, are part of the technical processes leading up to the retention of data, or are part of the security system.

M. (1) An advisory committee to the board of directors to the Property Insurance Association of Louisiana shall be formed. The advisory committee shall study and evaluate the public fire protection classification or grading for a public fire protection area, which shall include the Louisiana addendum to the ISO Fire Suppression Rating Schedule.

(2) The board of directors of the Property Insurance Association of Louisiana shall establish and provide for the meetings of the advisory committee which shall be composed as follows, with each individual member of the advisory committee serving as a voting member of the committee:

(a) Three members of the Property Insurance Association of Louisiana board of directors.

(b) One member from the Louisiana Fire Chiefs Association.

(c) One member from the Louisiana State Firemen's Association.

(d) One member from the Professional Fire Fighters Association of Louisiana.

(e) The director of the Fire Rating Division of the Property Insurance Association of Louisiana.

(f) The Louisiana State Fire Marshal.

(3) The chairman of the advisory committee shall be the executive director of the Property Insurance Association of Louisiana and shall be a non-voting member.

(4) The advisory committee shall serve in an advisory capacity to the board of directors of the Property Insurance Association of Louisiana.

Renumbered from R.S. 22:1405 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1960, No. 296, § 1. Amended by 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; Acts 2006, No. 809, § 1; Acts 2007, No. 420, § 1; § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2007, No. 468, § 1; Acts 2008, No. 900, § 1, eff. July 9, 2008; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011; Acts 2013, No. 33, § 1.

Validity—Acts 2007, No. 468

Due to the absence of duly adopted amendments in the enrolled version of Senate Bill No. 183 (enacted as Acts 2007, No. 468), as presented to and signed by the governor, the enacted provisions may be constitutionally infirm.

§ 1461. Board of review; membership; authority

A. A board of review shall be established within the Department of Insurance to review public fire protection grading issued by the Property Insurance Association of Louisiana when a request for review is properly submitted. The board of review shall be composed of the following membership, each member to be chosen by the specified organization from its membership, unless otherwise indicated:

(1) One member from the Louisiana Fire Chiefs Association.

(2) One member from the Louisiana Municipal Association.

(3) One member from the American Water Works Association, Southwest Section, who shall be a Louisiana member with experience in public fire protection.

(4) One member from the Louisiana Association of Public Safety Communications

Officers.

(5) One member who is an employee of the Louisiana Department of Insurance chosen by the commissioner of insurance.

B. A member of the board shall be elected by its membership as chairman for a term of one year.

C. (1) The initial member from the Louisiana Fire Chiefs Association and the initial member from the Louisiana Municipal Association shall each serve a term of three years; the initial member from the American Water Works Association, Southwest Section, shall serve a term of two years; and the initial member from the Louisiana Association of Public Safety Communications Officers shall serve a term of one year. Thereafter, such members shall serve a term of four years and no member shall serve more than two successive four-year terms.

(2) The member chosen by the commissioner of insurance shall serve a term concurrent with that of the commissioner making the appointment.

(3) If a member is unable to serve after being chosen by an organization, then another member from that organization shall be chosen after written notice of the vacancy and the reason for such vacancy is given to the other members of the board and the commissioner of insurance. The organization shall notify all members of the board and the commissioner of insurance of the new appointment.

D. Three members of the board shall constitute a quorum. No board member shall act in any case in which he has a personal pecuniary interest.

E. All decisions of the board shall include written reasons for the decisions. The vote of each member participating shall be recorded. The chairman shall only vote in the event of a tie.

F. The board shall establish rules and regulations for its own procedures not inconsistent with the provisions of the Louisiana Administrative Procedure Act (R.S. 49:951 et seq.). The board shall meet as determined by the chairman, but in any event, the board shall meet within ninety days after a proper request for review has been received. The board shall issue a decision within a period of ninety days after the board meets on such matter. The board shall meet in the public fire protection area for which a request for review has been filed.

G. The board of review shall have the authority to suspend a detrimental change in a public fire protection classification from the date a proper request for review is received until appropriate action is completed after a written decision has been issued. Upon completion of a hearing and review, the board shall instruct the Property Insurance Association of Louisiana to either reevaluate the public fire protection grading in accordance with its decision or impose the original public fire protection grading.

Renumbered from R.S. 22:1405.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 809, § 1.

§ 1462. Request for review of public fire protection grading

A. The board shall not have authority to review a public fire protection grading

issued by the Property Insurance Association of Louisiana unless all requirements of this Section have been satisfied.

B. A fire chief shall have sixty days from receipt of a public fire protection grading to review the results and dispute the grading by sending a dispute letter to the Property Insurance Association of Louisiana that specifically identifies the reasons for disagreement with the grading.

C. Within sixty days of receipt of the dispute letter from the fire chief, the Property Insurance Association of Louisiana shall send a written response to the fire chief specifically addressing each reason for disagreement with the grading. If such response is not sent within the sixty-day time period, then the fire chief shall have ten days to request the board to review the grading. The request for review shall be made in writing to the commissioner of insurance.

D. If the Property Insurance Association of Louisiana timely responds to the dispute letter of the fire chief, the fire chief shall have sixty days from receipt of the response to review it and either accept the response or request the board to review the disputed grading. The request for review shall be made in writing to the commissioner of insurance.

E. A fire chief shall not have authority to request the board to review a public fire protection grading unless he or his designee has attended the Professional Grading Assistance Program class, or has attended a class on the fire suppression grading schedule sponsored by the Louisiana Fire Chiefs Association or the Louisiana State Firemen's Association, or has attended a training seminar related to fire suppression grading that has been approved by either the Property Insurance Association of Louisiana or the Louisiana State University Fire and Emergency Training Institute.

Renumbered from R.S. 22:1405.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 809, § 1.

§ 1463. Standard of review; rehearing

A. The board of review shall determine whether the grading issued by the Property Insurance Association of Louisiana was proper according to that association's guidelines.

B. The fire chief and the Property Insurance Association of Louisiana shall both have the right to request that the board reconsider its decision. The request for rehearing shall be made in writing to the commissioner of insurance within ten days after receipt of the written decision of the board. The board may grant or deny the request for rehearing. If the request for rehearing is granted, the board shall meet within ninety days after granting the request for rehearing. The board shall issue a written decision within a period of ninety days after the rehearing. The board shall have authority to grant only one rehearing of a review of a public fire protection grading.

Renumbered from R.S. 22:1405.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 809, § 1.

§ 1464. Rate filing

A. (1) Every insurer whose rates are subject to regulation under the provisions of this Subpart shall file with the commissioner, except as to individually rated excess insurance coverages which 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 commissioner.

(2) When a filing made pursuant to this Subsection is not accompanied by the information upon which the insurer or rating organization supports the rate filing, and the commissioner does not have sufficient information to determine whether the rate filing meets the requirements of this Subpart, it shall require such insurer or rating organization to furnish the information upon which it supports its filing, and the waiting periods provided in R.S. 22:1451(C)(1) shall commence as of the date the information is furnished to complete the filing.

(3) The commissioner is authorized to verify statistical data included in any rate filing made pursuant to this Section either by requiring substantiating written documentation or by inspecting records of insurers or rating organizations at the home office or any branch office of the insurer or rating organization.

B. An insurer may make a rate filing either by filing its final rates or by filing a loss cost multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by R.S. 22:1471.

C. Specific inland marine rates on risks specially rated by a rating organization shall become effective when filed with the commissioner and shall be deemed to meet the requirements of this Subpart until such time as the commissioner reviews the filing and shall remain in effect until such time as a new filing is made or by action of the commissioner.

D. All rates, supplementary rate information, and any supporting information filed under this Subpart shall be open to public inspection upon expiration of the forty-five-day period as set forth in R.S. 22:1451(C)(1), or upon disapproval, except for information which is deemed confidential, trade secret, or proprietary by the insurer or filer.

E. Notwithstanding any other provision in this Section to the contrary, a rate in excess of the rate provided in a filing otherwise applicable may be applied to an insured on a specific risk, provided the insurer files a written application to the commissioner stating the reasons for the excess rate and the excess rate is approved by the commissioner.

Renumbered from R.S. 22:1407 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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 1988, No. 357, § 1, eff. Sept. 1, 1988; Acts 1991, No. 814, § 2, eff. Oct. 19, 1991; Acts 2003, No. 456, § 1; Acts 2005, 1st Ex.Sess., No. 12, § 2, eff. Nov. 29, 2005; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1465. Disapproval of filings; rates; procedures

A. (1) The commissioner shall disapprove a rate in a competitive market only if he determines that the rate is inadequate or unfairly discriminatory. The commissioner shall disapprove a rate for use in a noncompetitive market only if he determines that the rate is excessive, inadequate, or unfairly discriminatory.

(2) If within the forty-five-day waiting period or any extension of this period as provided in R.S. 22:1451, the commissioner finds that a filing does not meet the requirements of this Subpart, he shall send to the insurer or rating organization which made such filings written notice of disapproval of such filing specifying wherein he finds such filing fails to meet the requirements of this Subpart and stating that such filing shall not become effective.

(3)(a) If at any time after a filing has become effective under R.S. 22:1451, the commissioner finds that a filing does not meet the requirements of this Subpart, he shall request a public hearing to be held 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 commissioner shall thereafter issue an order specifying in what respects, if any, the commissioner finds that such filing fails to meet the requirements of this Subpart, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective.

(b) If an insurer appeals the disapproval of a rate filing pursuant to R.S. 22:1469, the insurer may continue to use the disapproved rate pending a final ruling on such appeal. All funds collected by the insurer subsequent to the commissioner's rate disapproval but pending the final disposition of the appeal which are in excess of the previously approved rate shall be segregated and maintained by the insurer in an escrow account which shall be pledged to the commissioner for the benefit of the insureds.

B. (1) Any insurer whose rate filing is returned as incomplete more than once or disapproved or not acted upon within forty-five days from the date of receipt by the commissioner under this Subsection shall be given a public hearing upon written request made within thirty days of the return of the rate filing, disapproval of the rate filing, or inaction of the commissioner.

(2) If the commissioner, after conducting a public hearing, disapproves a new rate or rate change, he shall issue his order within thirty days of such hearing and shall specify the reasons why the new rate or rate change does not comply with the requirements of this Subpart. The commissioner's order shall state a date, not later than thirty days after the date of the order, on which the new rate or rate change shall be discontinued. 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.

C. Any person or organization aggrieved with respect to any filing which is in effect may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.; however, the insurer or rating organization that made the filing shall not be authorized to proceed under this Subsection.

Renumbered from R.S. 22:1408 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 1966, No. 136, § 1; Acts 2003, No. 456, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2009, No. 317, § 1.

§ 1466. 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 commissioner of insurance 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 the following: (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 commissioner 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 commissioner 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 otherwise licensed, for a kind or class of insurance subject to this Subpart, 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 commissioner 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 commissioner within sixty days of the date of its filing. Licenses issued pursuant to this Section shall remain in effect for three years unless sooner suspended or revoked by the commissioner. Licenses issued pursuant to this Section may be suspended or revoked by the commissioner in accordance and compliance with R.S. 49:961 in the event the rating organization ceases to meet the requirements of this Subsection. Every rating organization shall notify the commissioner promptly of every change in the following: (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 commissioner or process affecting such rating organization may be served.

B. Subject to rules and regulations which have been approved by the commissioner of insurance 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 commissioner at a public hearing held upon at least ten days' written notice to such rating organization and to such subscriber or insurer.

If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, the commissioner 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 commissioner as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, the commissioner shall order the rating organization to admit the insurer as a subscriber. If the commissioner 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 Subpart is hereby authorized, provided the filings resulting from such cooperation are subject to all the provisions of this Subpart which are applicable to filing generally. The commissioner of insurance may review such cooperative activities and practices and if, after a public hearing, it finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this Subpart, the commissioner 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 Subpart, 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 commissioner of insurance. No such notification shall be furnished to the commissioner if a public hearing will be required. All information 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 commissioner of insurance because of lack of credibility of data in the statistical base. All such filings shall be subject to actuarial interpretation by the commissioner 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).

(e) The Louisiana Title Insurance Statistical Services Organization.

Renumbered from R.S. 22:1409 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2006, No. 828, § 1; Acts 2009, No. 317, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1467. Louisiana Title Statistical Services Organization

A. Louisiana Title Statistical Services Organization is a private rating organization pursuant to R.S. 22:1466, authorized to make title insurance rate filings to the commissioner of insurance on behalf of its members, which shall be based on information derived from statistical plans developed by the Louisiana Title Statistical Services Organization and approved by the commissioner and not from individual expenses or from individual loss cost multipliers. Membership in Louisiana Title Statistical Services Organization shall be voluntary; however, no title insurer properly licensed to do business in the state of Louisiana shall be denied membership provided said title insurer complies with the charter and bylaws of the Louisiana Title Statistical Services Organization.

B. Subject to the provisions of Subsection A of this Section, the commissioner of insurance shall review the rates promulgated by the rating organization to determine whether they meet the requirements of this Subpart. Such review shall be made in the same manner and subject to the same procedure as is provided in R.S. 22:1464.

C. The board of directors for Louisiana Title Statistical Services Organization shall be elected by the membership, but at all times the board of directors shall include the following three members:

(1) One member who shall be the commissioner of insurance or his designee.

(2) One ex officio member who shall be the chairman of the House Committee on Insurance or a member of that committee designated by him.

(3) One ex officio member who shall be the chairman of the Senate Committee on Insurance or a member of that committee designated by him.

D. Each board member shall be entitled to one vote, except that the legislative members serving pursuant to Paragraphs (C)(2) and (3) of this Section 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.

E. There shall be no liability on the part of and no cause of action of any nature shall arise against Louisiana Title Statistical Services Organization 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 Subpart.

Renumbered from R.S. 22:1409.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 828, § 1.

§ 1468. 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, title, marine, and inland marine insurance to which this Subpart applies, any insurer may make written application to the commissioner of insurance 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 copy thereof shall also be sent simultaneously to such rating organization concerned.

(2) In the case of casualty insurance to which this Subpart applies, any insurer may make written application to the commissioner of insurance 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 commissioner for a kind of insurance, or for a class of insurance which is found by the commissioner 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 commissioner. Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies.

B. Repealed by Acts 2007, No. 459, § 3, eff. Jan. 1, 2008.

C. In considering the application for permission to file such deviation in the case of fire, marine, and inland marine insurance, the commissioner of insurance shall give consideration to the available statistics and the applicable principles for ratemaking as provided in R.S. 22:1464. The commissioner shall approve such application if the rate sought to be used meets the requirements of R.S. 22:1464(A)(3).

Renumbered from R.S. 22:1410 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 1966, No. 136, § 1; Acts 2003, No. 456, § 1; Acts 2006, No. 828, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1469. Appeal by subscriber to a rating organization

A. Any member of or subscriber to a rating organization may appeal to the commissioner 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 commissioner shall, after a public 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, he may, in the event the commissioner 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 commissioner within a reasonable time after the issuance of such order. All appeals shall be to the commissioner, who shall hold a public hearing on the appeal.

B. Any insurer or member of or subscriber to a rating organization may appeal from the decision of the commissioner in disapproving any proposed change in or addition to the filings of such insurer or member of or subscriber to a rating organization. All such appeals shall be to the Nineteenth Judicial District Court in accordance with the provisions of the Louisiana Code of Civil Procedure.

Renumbered from R.S. 22:1411 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Renumbered from R.S. 22:1411 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 2003, No. 456, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2009, No. 317, § 1.

§ 1470. Information to be provided 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 a written request from an insured, provide 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. The insurer may charge a reasonable rate to provide the information.

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 workers' compensation insurer, on such request may, within thirty days after written notice of such action, appeal to the commissioner of insurance, who, after a public 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 workers' compensation insurer may appeal in accordance with the procedures adopted by the commissioner 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.

Renumbered from R.S. 22:1412 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 1993, No. 547, § 1; Acts 2009, No. 317, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1471. 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 Subpart, shall be known as an advisory organization.

B. Every advisory organization shall file with the commissioner of insurance each of the following: (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 commissioner, or process issued at the direction of the commissioner may be served. and (4) an agreement that the commissioner may examine such advisory organization in accordance with the provisions of Chapter 8 of this Title.

C. If after a public hearing, the commissioner of insurance 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 Subpart, the commissioner 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 Subpart, 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 commissioner of insurance involving such statistics or recommendations issued under Subsection C of this Section. If the commissioner finds such insurer or advisory organization to be in violation of this Subsection, he may issue an order requiring the discontinuance of such violation.

E. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1413 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 2003, No. 456, § 1; Acts 2009, No. 317, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1472. 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 and penalties as provided by this Subpart. Joint reinsurance shall also be subject to the provisions of R.S. 22:1474 and Chapter 8 of this Title.

B. If, after a hearing, the commissioner of insurance finds that any activity or practice of any such group, association, or other organization is unfair, unreasonable, or otherwise inconsistent with the provisions of this Subpart, the commissioner shall issue a written order specifying in what respects such activity or practice is unfair, unreasonable, or otherwise inconsistent with the provisions of this Subpart, and shall require the discontinuance of such activity or practice.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1414 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 2003, No. 456, § 1; Acts 2009, No. 317, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1473. Rate administration

A. Recording and reporting of loss and expense experience. The commissioner of insurance shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with the commissioner, 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 commissioner in determining whether rating systems comply with the standards set forth in R.S. 22:1454. 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 commissioner shall give due consideration to the ratings systems on file with the commissioner 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 commissioner 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 commissioner, to insurers and rating organizations.

B. Interchange of rating plan data. Reasonable rules and plans may be promulgated by the commissioner of insurance 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 commissioner of insurance 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 commissioner of insurance may make reasonable rules and regulations necessary to effect the purposes of this Subpart, 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.

Renumbered from R.S. 22:1415 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 1989, No. 346, § 1; Acts 2003, No. 456, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1474. False or misleading information

No person or organization shall willfully withhold information from or knowingly give false or misleading information to the commissioner, any statistical agency designated by him, any rating organization, or any insurer which will affect the rates or premiums chargeable under this Subpart. A violation of this Section shall subject the one guilty of such violation to the penalties provided for in this Code.

Renumbered from R.S. 22:1416 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 2003, No. 456, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1475. Assigned risks; governing committee of the Louisiana Automobile Insurance Plan

A. With respect to casualty insurance to which this Subpart 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 commissioner of insurance. No domestic insurance company shall be denied servicing carrier status.

B. 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 designated by the commissioner of insurance.

(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. Repealed by Acts 2010, No. 703, § 2, eff. Jan. 1, 2011.

D. Repealed by Acts 2010, No. 703, § 2, eff. Jan. 1, 2011.

Renumbered from R.S. 22:1417 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1476. Assessments against insurers; dedications

A. (1) Sufficient funds determined by the commissioner of insurance shall be provided by all insurers doing business in this state and subject to this Subpart, by the payment of an assessment to be levied against them by the commissioner 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 Subpart, less returned premiums shall be deposited by the commissioner of insurance 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 commissioner of insurance, 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 Subpart, less returned premiums shall be deposited by the commissioner 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 commissioner of insurance, 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 commissioner of insurance shall be met by an annual assessment on each insurer subject to this Subpart 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 commissioner, 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 commissioner of insurance, 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.

Renumbered from R.S. 22:1419 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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.

§ 1477. 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.

Renumbered from R.S. 22:1421 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 1985, No. 228, § 1.

§ 1478. Right to employ attorney

In the event the commissioner deems it necessary to take any legal step or to file any suit or other proceedings to carry out the provisions of this Subpart, he 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 commissioner upon request.

Renumbered from R.S. 22:1422 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 296, § 1; Acts 2003, No. 456, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 1479. Consumer representation; attorney general

In all proceedings before the commissioner, 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 other appearing before the commissioner, and shall have the right to issue subpoenas to compel the attendance

of witnesses and the production of documents.

Renumbered from R.S. 22:1422.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 834, § 1. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1480. Repealed by Acts 2010, No. 703, § 2, eff. Jan. 1, 2011

§ 1481. Workers' compensation rates; safe workplace discount; criteria; inspection

A. Any insurer submitting rates and rating plans under this Subpart for workers' compensation policies may, but shall not be required to, provide for a safe workplace discount on workers' 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.

Renumbered from R.S. 22:1424 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 664, § 1.

§ 1482. Military personnel premium discount; rebates

A. 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. 22:838 and 831 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.

Renumbered from R.S. 22:1425 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 770, § 1. Amended by Acts 2005, No. 408, § 1, eff. July 11, 2005; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

Supersedure of Rules and Regulations—Acts 2005, No. 408

Section 4 of Acts 2005, No. 408 (§ 1 of which amends subsecs. A and B and pars. (C)(3) and (5) of this section) provides:

"Section 4. Existing rules and regulations governing the discount of the automobile liability insurance premiums required by R.S. 22:1425 shall be superseded by any such rules and regulations adopted subsequent to the effective date of this Act."

Acts 2005, No. 408 became effective July 11, 2005 upon signature by the governor.

§ 1482.1. Military personnel premium discount for homeowner's insurance

A. Beginning August 1, 2008, and thereafter, every homeowner's insurer authorized to transact business in this state and offering homeowner's coverage in this state may provide to active military personnel based in this state a discount of ten percent of the premium on any homeowner's insurance policy purchased in this state to cover immovable property owned by such military personnel.

B. 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 insurer.

(3) Other such provisions necessary for the proper implementation of this Section.

Renumbered from R.S. 22:1425.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 849, § 1.

§ 1483. Premium discounts, credits, rate differentials, adjustments in deductibles, and other adjustments for compliance with building codes and for damage mitigation

A. Any insurer required to submit rates and rating plans to the commissioner of insurance shall provide an actuarially justified discount, credit, rate differential, adjustment in deductible, or any other adjustment to reduce the insurance premium to insureds who build or retrofit a structure to comply with the requirements of the State Uniform Construction Code.[1]

B. Any insurer required to submit rates and rating plans to the commissioner of insurance shall provide an actuarially justified discount, credit, rate differential, adjustment in deductible, or any other adjustment to reduce the insurance premium to insureds who install mitigation improvements or retrofit their property utilizing construction techniques demonstrated to reduce the amount of loss from a windstorm or hurricane. Such mitigation improvements or construction techniques shall include but not be limited to roof deck attachments; secondary water barriers; roof coverings; brace gable ends; construction techniques which enhance or reinforce roof strength; roof-covering performance; roof-to-wall strength, wall-to-floor-to-foundation strength; opening protection; and window, door, and skylight strength.

C. The commissioner of insurance, in consultation with the State Uniform Construction Code Council, shall, no later than January 1, 2008, promulgate rules and regulations in accordance with the Administrative Procedure Act [2] to implement the provisions of this Section. The rules and regulations may include but not be limited to the following:

(1) Provisions defining and delineating the criteria for discounts, credits, rate differentials, adjustments in deductibles, or any other adjustments to reduce the insurance premium and how such discounts, credits, rate differentials, adjustments in deductibles, or any other adjustments are computed in determining their application in each premium quoted.

(2) Those items necessary for an insurer to compute or otherwise determine the actuarially justified amount of any premium rate reduction, discount, credit, rate differential, reduction in deductible, or other adjustment available to an insured.

(3) Provisions establishing the inspection and certification requirements for insureds who comply with the provisions of this Section.

(4) Recordkeeping requirements for insurers.

Renumbered from R.S. 22:1426 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 323, § 1, eff. July 9, 2007.

[1] R.S. 40:1730.21 et seq.

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

§ 1484. 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. For an insurance company to be entitled to any additional premium, the insured must receive a billing notice and either an explanation of any premium increase or a statement that asks the insured to contact either the insurance company or its producer if the insured has any questions about the billing notice or the premium increase, within the first sixty days of the effective date of the policy. 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.

Renumbered from R.S. 22:1464 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 359, § 1, eff. Sept. 1, 1988. Amended by Acts 1989, No. 658, § 1; Acts 1991, No. 769, § 1; Acts 1993, No. 196, § 1; Acts 2006, No. 784, § 1, eff. June 30, 2006; Acts 2006, No. 787, § 1; Acts 2010, No. 703, § 1, eff. Jan. 1, 2011.

§ 1485. 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.

Renumbered from R.S. 22:1464.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 185, § 1.

§§ 1486. Redesignated as R.S. 22:75 by Acts 2010, No. 703, § 3, eff. Jan. 1, 2011

§ 1487. 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.

Renumbered from R.S. 22:1473 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 959, § 1.

§ 1488. Homeowner's insurance clarity; publication of aggregate data; penalties

A. (1)(a) Each insurance company authorized to write homeowner's insurance in this state shall annually submit to the commissioner, commencing on or before May 1, 2015, for homeowner's insurance policies, the total amount of direct paid losses reported by peril less all deductibles, the number of policies written, and the direct written premiums for the prior calendar year. The insurance company shall report the computations to the commissioner by zip code and parish. The information received by the commissioner shall be aggregated across all insurance companies collectively, and the aggregated totals shall be arranged by zip code and parish.

(b) "Homeowner's insurance" as used in this Section shall include condominium

insurance, residential fire insurance, renter's and tenant's insurance, and mobile home and manufactured housing insurance.

(c) Creditor-placed homeowner's insurance, condominium association insurance, and commercial insurance are excluded from the requirements of this Section.

(2) The commissioner shall compile and publish on the Department of Insurance website by June first annually the aggregated total of the data provided in Paragraph (1) of this Subsection by zip code and parish for the prior calendar year.

(3) Each insurance company authorized to write homeowner's insurance in this state shall annually submit to the commissioner, commencing on or before May 1, 2015, computations of the direct paid losses by peril, the number of policies written, and direct written premiums, by zip code and parish, by calendar year for the prior calendar year, for each of the following perils:

(a) Fire.

(b) Wind and hail.

(c) Catastrophe wind and hail per data call by the commissioner.

(d) Flood.

(e) All other perils.

(4) The commissioner shall post a link to the data on the Department of Insurance website in a prominent position on the website's home page.

B. The commissioner shall post on the Department of Insurance website a general description of the ratemaking methodology that the commissioner permits insurance companies to use in establishing their homeowner's insurance rates.

C. (1) Commencing on or before May 1, 2015, each insurance company authorized to write homeowner's insurance in this state shall provide the information required pursuant to Subsection A of this Section, commencing with the 2004 calendar year. Voluntary submissions of the information required by Subsection A of this Section for calendar years prior to 2004 may be submitted and shall be compiled and posted by the commissioner in the same manner.

(2) The commissioner shall compile the aggregated totals for each calendar year submitted and publish the aggregated totals on the Department of Insurance website pursuant to Paragraph (A)(2) of this Section.

D. (1) Upon written request of an insurance company, the commissioner may modify or extend for an additional time period, for good cause shown, the reporting requirements of this Section. Any modifications or extensions granted by the commissioner shall be noted on the Department of Insurance website, along with a projected date of compliance. Good cause may include but is not limited to either of the following:

(a) The insurance company's limited percentage of the total homeowner's insurance market in this state.

(b) The undue burden of compiling and reporting computation, data, and other information required by this Section due to the manner, format, or method in which the insurance company has stored the computations, data, or other information required.

(2) Any insurance company that fails to timely comply with the reporting requirements of this Section shall be given notice by the commissioner of the failure and provided thirty days to comply. Any insurance company that fails to comply on or before the thirtieth day, unless modified or extended by the commissioner, shall be fined ten thousand dollars per month by the commissioner until the date of compliance. Any funds collected pursuant to this Paragraph shall be deposited into the state general fund. These fines shall not be waived or reduced except by an act of the legislature.

(3) The commissioner shall waive or modify the reporting requirements of this Section if an insurance company meets any of the following criteria:

(a) Does not store the computations, data, or other information required.

(b) Is required to materially upgrade, modify, redevise, or reprogram computer systems to provide the computations, data, or other information required.

(c) Is required to significantly divert limited resources to provide the computations, data, or other information required.

E. Any information reported to the commissioner by an insurer as required by this Section shall be treated as confidential. Use of the information is limited solely to the purposes authorized in this Section, and the information submitted by each insurer pursuant to this Section shall be exempt from the Public Records Law, R.S. 44:1 et seq.

F. Each report submitted by an insurance company pursuant to this Section shall include a notarized affidavit executed by an executive of that company attesting to the validity of the data reported.

G. The commissioner may issue such rules and regulations as may be necessary or 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, R.S. 49:950 et seq.

H. The provisions of this Section shall become void on May 1, 2017.

Added by Acts 2014, No. 427, § 1.

Termination of Provisions

For provisions regarding termination of the provisions of this section, see subsec. H.

SUBPART P. USE OF CREDIT INFORMATION

§ 1501. Purpose

The purpose of this Subpart 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.

Renumbered from R.S. 22:1481 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1502. Scope

This Subpart applies to personal insurance and not to commercial insurance. For purposes of this Subpart, "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 Subpart.

Renumbered from R.S. 22:1482 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1503. Definitions

For the purposes of this Subpart, 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.

Renumbered from R.S. 22:1483 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1504. 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.

(10) Use credit information which would increase the expiring premium, due to a change in credit information, for policies that renew between August 15, 2006 and December 31, 2006.

Renumbered from R.S. 22:1484 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1. Amended by Acts 2006, No. 688, § 1.

§ 1505. 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.

Renumbered from R.S. 22:1485 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1506. 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.

Renumbered from R.S. 22:1486 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1507. 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.

Renumbered from R.S. 22:1487 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1508. 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."

Renumbered from R.S. 22:1488 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1509. 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.

Renumbered from R.S. 22:1489 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1510. 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.

Renumbered from R.S. 22:1490 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1511. 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.

Renumbered from R.S. 22:1491 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1512. 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.

Renumbered from R.S. 22:1492 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1513. Severability

If any portion of this Subpart 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.

Renumbered from R.S. 22:1493 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

§ 1514. Applicability

This Subpart shall apply to personal insurance policies either written to be effective or renewed on or after nine months from August 15, 2003.

Renumbered from R.S. 22:1494 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1256, § 1.

PART V. COLLISION DAMAGE WAIVER LAW

§ 1521. Title of Part

This Part shall be known and may be cited as the "Louisiana Collision Damage Waiver Law".

Renumbered from R.S. 22:2091.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

§ 1522. 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.

Renumbered from R.S. 22:2091.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

§ 1523. 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.

Renumbered from R.S. 22:2091.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990. Amended by Acts 1990, No. 589, § 1, eff. July 19, 1990.

§ 1524. 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.

Renumbered from R.S. 22:2091.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

§ 1525. 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. 22:1296.

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."

Renumbered from R.S. 22:2091.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, §§ 2, 3, eff. Jan. 1, 1990.

§ 1526. 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.

Renumbered from R.S. 22:2091.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

§ 1527. 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.

Renumbered from R.S. 22:2091.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

§ 1528. Injunctions

The commissioner may seek temporary and permanent injunctions restraining violations or attempted violations of this Part in the Nineteenth Judicial District Court.

Renumbered from R.S. 22:2091.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

§ 1529. Penalties

A. Any lessor who is found by the commissioner 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.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:2091.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990. Amended by Acts 2009, No. 317, § 1.

§ 1530. 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.

Renumbered from R.S. 22:2091.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 773, § 2, eff. Jan. 1, 1990.

CHAPTER 5. PRODUCERS AND OTHER REGULATED ENTITIES

PART I. PRODUCERS

SUBPART A. QUALIFICATIONS AND LICENSING

§ 1541. Purpose and scope

This Subpart 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 as set forth in this Subpart.

Renumbered from R.S. 22:1131 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1542. Definitions

As used in this Subpart, unless the context requires otherwise, the following definitions shall be applicable:

(1) "Authorized insurer" shall have the same definition as set forth in R.S. 22:46.

(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 a 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. 22:1547.

(6) "Insurance producer" or "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 this 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. 22:46.

(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. 22:47 and R.S. 6:969.6, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, or 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. 22:1547(A)(1) through (6).

(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 if 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: 431 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) "Travel insurance" shall mean that line of insurance defined in R.S. 22:1782.1(3).

(21) "Uniform application" shall mean the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

(22) "Uniform Business Entity Application" shall mean the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

Renumbered from R.S. 22:1132 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2014, No. 117, § 1.

§ 1543. 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.

Renumbered from R.S. 22:1133 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1544. Exceptions to licensing; prohibitions

A. Nothing in this Subpart 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, if 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, if 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 employer relative to the insurance interests of the employer or of the subsidiaries or business

affiliates of the employer if 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 if those employees are not directly compensated based on the volume of premiums that may result from these services and if 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 Subpart, "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 he or any person who owns directly or indirectly more than ten percent of the beneficial interest in a business entity applying for a license, is either a citizen of, resident of, domiciled in, or the commissioner determines that he or the beneficial owner maintains 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.

Renumbered from R.S. 22:1134 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1545. Examination

A. A resident individual applying for an insurance producer license shall pass an examination unless exempt pursuant to R.S. 22:1551. 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. (1) Any person applying for a license as an insurance producer, prior to taking the examination required by this Subpart, 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. 22:1571.

(2) This Subsection shall not apply to any applicant seeking authorization to write industrial fire, limited life, health and accident, surety, title, surplus lines, or credit insurance business only.

(3) A person applying for a license as an insurance producer for authorization to write life insurance and having any of the following designations: Certified Employee Benefit Specialist (CEBS), Chartered Financial Consultant (ChFC), Certified Insurance Counselor (CIC), Certified Financial Planner (CFP), Chartered Life Underwriter (CLU), The Fellow, Life Management Institute (FLMI) or The LUTC Fellow Designation (LUTCF) shall be exempt from any prelicensing education requirements.

(4) A person applying for a license as an insurance producer for authorization to write health and accident insurance and having any of the following designations: Registered Health Underwriter (RHU), Certified Employee Benefit Specialist (CEBS), Registered Employee Benefits Consultant (REBC) or Health Insurance Associate (HIA) shall be exempt from any prelicensing education requirements.

(5) A person applying for a license as an insurance producer for authorization to write property or casualty insurance and having any of the following designations: Accredited Advisor in Insurance Program (AAI), Associate in Risk Management (ARM), Certified Insurance Counselor (CIC) or Chartered Property and Casualty Underwriter (CPCU) shall be exempt from any prelicensing education requirements.

(6) A person applying for a license as an insurance producer to write any line of insurance and having a bachelor's degree or higher from an accredited college or university with major course work in insurance shall be exempt from any

prelicensing education requirements.

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. Repealed by Acts 2009, No. 485, § 3, eff. Jan. 1, 2010.

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.

I. (1) The commissioner of insurance shall prepare, publicly announce, and publish a report that summarizes statistical information relating to life insurance producer examinations administered during the preceding calendar year. Each report shall include the following information for all examinees combined and separately by gender, race or ethnicity, race or ethnicity within gender, education level, and native language:

(a) The total number of examinees.

(b) The percentage and number of examinees who passed the examination.

(c) Standard deviation of scaled scores on the examination.

(2) The commissioner of insurance shall prepare and make available upon request a report of summary statistical information relating to each life insurance test form administered during the preceding calendar year. The report shall show, for each test form, for all examinees combined and separately for African-American examinees, American Indian examinees, Hispanic examinees, white examinees, and other examinees, the correct-answer rate and correlations.

(3) The reports referred to in Paragraphs (1) and (2) of this Subsection shall be published no later than May first of the current year.

J. The commissioner of insurance may provide to a testing service provider under contract with the Department of Insurance any demographic information received by the department on applications relating to examinations taken to qualify for an insurance producer license if the commissioner requires the provider to review and analyze examination results in conjunction with the education level, gender, native language, race, or ethnicity of examinees.

Renumbered from R.S. 22:1135 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2008, No. 385, § 1, eff. July 1, 2008; Acts 2009, No. 485, § 1, eff. Jan. 1, 2010; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1546. 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 as set forth in R.S. 22:1554.

(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. 22:821.

(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 in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

(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. 22:821.

(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) Repealed by Acts 2009, No. 485, § 3, eff. Jan. 1, 2010.

(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. (1) The commissioner of insurance may require any documents deemed necessary to verify the information contained in an application.

(2) In order to make a determination of license eligibility, the commissioner of insurance may require fingerprints of applicants and submit the fingerprints and the fees required to perform the criminal history record checks to the Louisiana Bureau of Criminal Identification and Information for state and national criminal history record checks. The commissioner of insurance shall require a criminal history record check on each applicant in accordance with this Subpart. The commissioner of insurance shall require each applicant to submit a full set of fingerprints in order for the commissioner of insurance to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(3) The commissioner of insurance may contract for the collection, transmission, and re-submission of fingerprints required under this Section. If the commissioner of insurance does so, the fee for collecting and transmitting fingerprints and the fee for the criminal history record check shall be payable directly to the contractor by the applicant. The commissioner of insurance may agree to a reasonable fingerprinting fee to be charged by the contractor.

(4) The commissioner of insurance shall treat and maintain an applicant's fingerprints and any criminal history record information obtained under this

Section as confidential and shall apply security measures consistent with the Criminal Justice Information Services Division of the Federal Bureau of Investigation standards for the electronic storage of fingerprints and necessary identifying information and limit the use of records solely to the purposes authorized in this Section. The fingerprints and any criminal history record information shall be exempt from the public records law, R.S. 44:1 et seq., shall not be subject to subpoena, other than a subpoena issued in a criminal proceeding or investigation, shall be confidential by law and privileged, and shall not be subject to discovery or admissible in evidence in any private civil action.

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, as defined in R.S. 22:46, 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, H. Repealed by Acts 2011, No. 94, § 2, eff. Jan. 1, 2012.

Renumbered from R.S. 22:1136 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2005, No. 228, § 1, eff. June 29, 2005; Acts 2009, No. 317, § 1; Acts 2009, No. 485, § 1, eff. Jan. 1, 2010; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1547. License

A. Unless denied licensure pursuant to R.S. 22:1554, persons who have met the requirements of this Subpart 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 including benefits of endowment and annuities, 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) 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.

(5) Casualty, which provides insurance coverage against legal liability, including that for death, injury or disability, or damage to real or personal property.

(6) Personal lines, which provides property and casualty insurance coverage to

individuals and families for primarily noncommercial purposes.

(7) Title.

(8) Credit which includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, or any other form of insurance offered in connection with an extension of credit to partially or wholly extinguish that credit obligation and that is designated by the insurer as limited line credit insurance. The amount of credit insurance issued pursuant to a credit transaction shall not exceed the total sum payable under the contract including all loan finance and credit service charges.

(9) Travel insurance as defined in R.S. 22:1782.1(3).

(10) Limited life, health and accident, which provides insurance coverage pursuant to R.S. 22:142. A license for limited life may allow the producer to sell life insurance in an amount not to exceed thirty thousand dollars when appointed by an insurer which meets the minimum financial requirements of, and is licensed pursuant to, R.S. 22:82(A)(1) or 112(A)(1), and when such policies are issued by such insurer.

(11) Industrial fire.

(12) Surety which provides insurance or bond that covers obligations to pay debts of, or answer for the default of another, including faithlessness in a position of public or private trust. For purpose of limited line licensing, surety does not include surety bail bonds.

(13) Bail bonds.

(14) Surplus lines, subject to the requirements of Subsection I of this Section.

(15) 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 as authorized by R.S. 22:821.

(3) Prior to the filing date for application for renewal of a license, the licensee shall comply with continuing education requirements in R.S. 22:1573 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 license to lapse may, within two 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 two 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 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 thirty 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. 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 in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

H. A duplicate license may be issued for any lost, stolen, or destroyed license issued pursuant to this Subpart 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 as authorized by R.S. 22:821.

I. Any licensed property and casualty 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. 22:821, for each license year during any part of which the license is in effect. The license shall remain in force until the biannual renewal date.

(3) The applicant shall pass 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.

Renumbered from R.S. 22:1137 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2006, No. 605, § 1, eff. June 23, 2006; Acts 2009, No. 317, § 1; Acts 2009, No. 485, § 1, eff. Jan. 1, 2010; Acts 2010, No. 967, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2014, No. 117, § 1; Acts 2014, No. 118, § 1.

§ 1548. Nonresident licensing

A. Unless denied licensure pursuant to R.S. 22:1554, 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 home state.

(2) The person has submitted the proper request for licensure and has paid the fees required by R.S. 22:821.

(3) The person has submitted or transmitted to the commissioner of insurance the application for licensure that the person submitted to his 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 Subpart, the same 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 the fee authorized by R.S. 22:821.

(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 Subpart 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 Subpart, 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: 431 et seq.

E. Notwithstanding any other provision of this Subpart, 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. 22:1547(A)(1) through (6).

Renumbered from R.S. 22:1138 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1549. 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 commissioner 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 as set forth in R.S. 22:821.

(5) Upon approval of the application, but prior to issuance of the license, the applicant shall submit a registration fee as set forth in R.S. 22:821.

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 the fee as set forth in R.S. 22:821.

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 the registration fee required by R.S. 22:821 for every 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, if all of the following are 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 producer pursuant to another provision of this Subpart, unless the entity or individual actually holds the applicable license.

G. If a specialty limited lines credit insurance producer violates any provision of this Subpart, the commissioner of insurance may, in accordance and compliance with R.S. 49:961, impose any penalties he deems necessary or appropriate to enforce the provisions of this Subpart, 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 Subpart has occurred, or any combination of penalties authorized by this Subpart.

H. The specialty limited lines credit insurance producer license shall be available equally to residents and nonresidents; however, 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 Subpart.

K. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1138.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 170, § 1. Amended by Acts 2003, No. 933, § 1; Acts 2003, No. 1224, § 1; Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1550. Specialty limited lines motor vehicle title insurance producer licenses

A. (1) A licensed insurance producer or limited lines motor vehicle title insurance producer may be issued a specialty limited lines motor vehicle title insurance producer license pursuant to the provisions of this Section.

(2) No producer shall sell, solicit, or negotiate motor vehicle title insurance pursuant to a specialty limited lines motor vehicle title insurance producer license other than in connection with retail sales of motor vehicles in which the transaction exceeds one thousand dollars and as provided in rules and regulations adopted by the commissioner of insurance.

(3) All insurance written pursuant to a specialty limited lines motor vehicle title insurance producer license shall be issued by a domestic title insurer or foreign or alien title insurer admitted in this state.

B. (1) For a specialty limited lines motor vehicle title insurance producer license to be issued pursuant to this Section, an applicant shall submit to the commissioner of insurance all of the following:

(a) An application, submitted in a manner prescribed by the commissioner of insurance, containing such information as prescribed by the commissioner.

(b) A list of the physical locations where activities authorized by the specialty limited lines motor vehicle title insurance producer license will be conducted.

(c) A list of the employees or representatives of the applicant, as of the date of application, to be registered pursuant to this Section.

(d) An application fee in the amount set forth in R.S. 22:821.

(2) Upon approval of the application, but prior to issuance of the license, the applicant shall also submit a registration fee in the amount set forth in R.S. 22:821.

C. Following initial issuance of the specialty limited lines motor vehicle title insurance producer license, the licensee shall submit an annual renewal application, in a manner prescribed by the commissioner of insurance, along with an annual renewal fee as set forth in R.S. 22:821.

D. The licensee shall submit, in a manner prescribed by the commissioner of insurance, a current list of employees and representatives for verification by the commissioner every six months in addition to a registration fee as required by R.S. 22:821 for every employee or representative not previously registered.

E. A specialty limited lines motor vehicle title insurance producer license issued pursuant to this Section authorizes an employee or representative of the license holder to participate in enrollment of retail motor vehicle sales customers in the types of insurance specified in this Section without being licensed if all of the following are 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 motor vehicle title 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 motor vehicle title 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 producer pursuant to another provision of this Subpart, unless the entity or individual actually holds the applicable license.

G. If a specialty limited lines motor vehicle title insurance producer violates any provision of this Subpart, the commissioner of insurance may, in accordance and compliance with R.S. 49:961, impose any penalties he deems necessary or appropriate to enforce the provisions of this Subpart, 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 Subpart has occurred, or any combination of penalties authorized by this Subpart.

H. The specialty limited lines motor vehicle title insurance producer license shall be available equally to residents and nonresidents; however, if the laws or regulations of any other state would not permit a specialty limited lines motor vehicle title 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 motor vehicle title insurance producer license as nonresidents under this Section.

I. A licensee under this Section may receive commissions or other compensation for services rendered in connection with the sale of motor vehicle title 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 Subpart.

K. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1138.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 360, § 1, eff. June 13, 2006. Amended by Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1551. 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. 22:1546. 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 two 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) Any applicant for a license to represent a limited life, health and accident insurer.

(3) Any applicant who shall be licensed to act only as a producer with respect to life, health, and accident insurance on borrowers or debtors or with respect to property and casualty insurance on collateral and involuntary unemployment, commonly known as credit insurance.

(4) Any applicant who shall be licensed to act only as a producer with respect to travel insurance.

(5) 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.

Renumbered from R.S. 22:1139 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2009, No. 485, § 1, eff. Jan. 1, 2010; Acts 2014, No. 117, § 1; Acts 2015, No. 58, § 1.

§ 1552. 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.

Renumbered from R.S. 22:1140 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1553. 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. Repealed by Acts 2009, No. 485, § 3, eff. Jan. 1, 2010.

Renumbered from R.S. 22:1141 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1554. 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. 22:1961 et seq. or fraud under R.S. 22:1964 et seq.

(7) The conviction or nolo contendere plea to any felony, participation in a pretrial diversion program pursuant to a felony charge, suspension and deferral of sentence and probation pursuant to Article 893 of the Code of Criminal Procedure, 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 Subpart.

(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. 22:1922(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 in accordance and compliance with R.S. 49:961, the commissioner shall notify the applicant and advise the applicant in writing of the reasons for the denial. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

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, in accordance and compliance with R.S. 49:961, 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. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

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, in accordance and compliance with R.S. 49:961, 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 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 Subpart, 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 Subpart against any person who is under investigation for or charged with a violation of this Subpart, 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.

Renumbered from R.S. 22:1142 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2003, No. 293, § 1; Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2014, No. 70, § 1.

§ 1555. Liability of producers on binder

The commissioner of insurance may suspend or revoke the license of any producer issuing or purporting to issue any binder on behalf of any insurer for which he is not then authorized to bind.

Renumbered from R.S. 22:632 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1556. License to solicit or transact bail; prohibited activities

A. A bail bond producer 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 bond producer 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 bonds 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 bonds 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 Chapter 12 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 Chapter 12 of this Title, subject to the provisions of Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950.

Renumbered from R.S. 22:1142.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 497, § 1, eff. June 20, 2003. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1557. 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 Subpart at the time of the sale, solicitation, or negotiation and was so licensed at that time.

(4) An insurance producer may pay or assign commissions, service fees, brokerage fees or other valuable consideration to an insurance agency or to persons who are not licensed as producers in Louisiana but are licensed in their state of domicile and act only to assist producers licensed in this state in placing business with insurers authorized to do business in this state.

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 such an 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 such an insurance advisory committee who receives without authorization all or any portion of such commission shall also be in violation of this Subsection.

(2) Any person who violates 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. 22:1554.

C. The commission paid by each fire, casualty, surety, fidelity, guaranty, and bonding insurer doing business in this state to its producers in this state shall be uniform and equal as to all classes of producers of such insurer throughout this state.

Renumbered from R.S. 22:1143 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2010, No. 967, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1558. 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 Subpart. 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 amounts set forth in R.S. 22:821. Any insurer who fails to file its renewal company appointments will be fined ten dollars per license named in its appointment form.

(4) An appointment as provided for in this Section shall remain in full force and effect until the following date of renewal, unless the license of the appointed producer named therein is revoked by the commissioner as provided for in this Subpart, 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 appointed to represent, if such producer is under contract with such insurer. However, no commissions shall be paid by such insurer to the producer until the appointment has been recorded by 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 in this Section may be issued by an insurer in the name of such partnership, corporation, or other business entity if all persons in such partnership, corporation, or other business entity actively engaged in soliciting, negotiating, or effecting contracts of insurance or renewals thereof also hold an active producer license issued in accordance with the provisions of this Subpart.

Renumbered from R.S. 22:1144 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1559. 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. 22:1554, 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. 22:1554, 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. 22:1554. 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 of this Section had the insurer then known of its existence.

D. (1) Within fifteen days after making any notification required by Subsections A, B, or C of this Section, 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. 22:1554, 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, an insurer, the authorized representative of the insurer, a producer, the commissioner of insurance, or 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 not be subject to civil liability. No civil cause of action shall arise against these entities or their respective producers 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 pursuant to Subsection B of this Section was reported to the commissioner, if the propriety of any termination for cause pursuant to 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 Subpart, 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 Subpart 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 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.

Renumbered from R.S. 22:1145 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1560. 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. 22:1548, 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.

Renumbered from R.S. 22:1146 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1561. 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 Subpart, 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. 22:821.

Renumbered from R.S. 22:1147 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1562. 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. 22:1554.

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 insurers 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 insurers 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 provided in Paragraph (3) of this Subsection, any person 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 Subpart 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 or producer 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 producer.

Renumbered from R.S. 22:1148 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2001, No. 275, § 1, effective June 1, 2001; Acts 2001, No. 1158, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1563. 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. 22:1554(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. 22:1554(A)(14).

Renumbered from R.S. 22:1149 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1564. 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 in this Section.

B. (1)(a) Any insurer 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. 22:691 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 limited benefit health insurance policies or contracts authorized to be issued in this state.

Renumbered from R.S. 22:1150 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2003, No. 378, § 1, eff. January 1, 2004; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1565. Other laws

All laws and parts of laws of this state inconsistent with this Subpart are hereby superseded with respect to matters covered by this Subpart.

Renumbered from R.S. 22:1151 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002.

§ 1566. Health insurance navigators; definitions

A. As used in this Section:

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

(2) "Exchange" means any health benefit exchange established or operating in this state, including any exchange established or operated by the United States

Department of Health and Human Services or any other federal office or agency.

(3) "Navigator" means any individual or entity who meets at least one of the following requirements:

(a) Receives any funding, directly or indirectly, from an exchange, the state, or the federal government to perform any of the activities and duties identified in 42 U.S.C. § 18031(i).

(b) Is described or designated by an exchange, the state, or any office or agency of the federal government, or who could be reasonably described or designated as a navigator.

(c) Is employed by or is a volunteer on behalf of a navigator or navigator entity for the purposes of conducting consumer outreach or education, or for the purposes of facilitating enrollment in qualified health plans.

(4) "Non-navigator personnel" means any individual or entity that facilitates enrollment of individuals or employers in a health benefit plan or public insurance program offered through an exchange and is certified, designated, or reasonably described as an in-person assister, enrollment assister, application counselor, or application assister.

B. (1) The legislature finds that regulation of navigators and non-navigator personnel, including registration or licensure by the commissioner, to ensure that they are properly trained and knowledgeable in the subject matter of individual and group health insurance benefit plans and insurance coverages as necessary to avoid substantial risk to the health, safety, and welfare of the people of this state.

(2) Navigators and non-navigator personnel shall be subject to regulation by the commissioner as provided in this Section.

(a) No individual or entity shall act as, offer to act as, or market any service as a navigator in this state unless licensed as a navigator by the commissioner pursuant to this Section.

(b) Individuals or entities conducting activities as non-navigator personnel, such as in-person assisters, enrollment assisters, application counselors, or application assisters, shall register with the commissioner in the manner and form prescribed by the commissioner. An entity conducting non-navigator activities may register its non-navigator personnel with the commissioner on their behalf.

(3) The following individuals or entities are exempt from the provisions of this Section and shall not be considered navigators or non-navigator personnel:

(a) Individuals who facilitate enrollment in a health benefit plan without receiving any form of direct or indirect compensation or who are employed by an employer who directly or indirectly benefits from enrollment in a health benefit plan, such as individuals assisting in the enrollment of family members, tutors acting for a minor child or acting as a continuing tutor, individuals with the authority to contract on behalf of interdicted persons, or a mandatary with the authority to contract on behalf of a principal.

(b) Employees of an employer who facilitate enrollment in the health benefit plan of the employer.

(c) A licensed insurance producer.

(d) An attorney in good standing who is licensed or authorized to act as an attorney in this state.

(e) An employee of a health insurance issuer, including a health maintenance organization.

(f) Any individual or entity granted an exemption by the commissioner. For the purposes of granting exemptions from the provisions of this Section, the commissioner may grant exemptions in a manner and form determined by the commissioner.

C. (1) An individual applying for registration as non-navigator personnel with the commissioner shall complete a registration form as prescribed by the commissioner.

(2) Any individual applying for a navigator license shall make application to the commissioner on a form prescribed by the commissioner. Such individual shall meet each of the following requirements:

(a) Be at least eighteen years of age.

(b) Intends to conduct business as a navigator in this state.

(c) Is not disqualified for having committed any act that would be grounds for denial or revocation of an insurance producer license pursuant to R.S. 22:1554.

(d) Has completed all required training and education prescribed by any office or agency of the federal government or by an exchange.

(e) Has identified the entity licensed as a navigator with which he is affiliated and by which he is supervised, if applicable.

(3) Each entity licensed as a navigator shall, in a manner and frequency prescribed by the commissioner, provide the commissioner with an accurate list of all licensed individual navigators that it employs, in addition to completing an application for a navigator license.

(4) A navigator license shall be valid for a period of two years from the date the license is issued. The commissioner shall prescribe the form for an application for renewal of a license.

(5) An individual applying for a navigator license shall submit any documents that the commissioner deems necessary to verify the information contained in a license application, shall submit a full set of fingerprints to the commissioner, and shall successfully complete a criminal history and regulatory background check as provided for pursuant to this Section.

(6) For any individual applying for licensure as or licensed as a navigator, the

commissioner may prescribe any education, training, or examinations in addition to education, training, or examinations required by any office or agency of the federal government or by an exchange; however, such additional education, training, or examinations shall not exceed thirty hours for initial education, training, or examinations and fifteen hours per year for continuing educational purposes when combined with education, training, or examinations required by any office or agency of the federal government or by an exchange.

D. (1) In order to make a determination of license eligibility for individuals applying for a navigator license, the commissioner shall require fingerprints of applicants and submit the fingerprints and the fees required to perform the criminal history record checks to the Louisiana Bureau of Criminal Identification and Information for state and national criminal history record checks. The commissioner shall require a criminal history record check on each applicant in accordance with this Subsection. The commissioner shall require each applicant to submit a full set of fingerprints in order for the commissioner to obtain and receive national criminal history records from the Criminal Justice Information Services Division of the Federal Bureau of Investigation.

(2) The commissioner may contract for the collection, transmission, and resubmission of fingerprints required under this Subsection. If the commissioner does so, the fee for collecting and transmitting fingerprints and the fee for the criminal history record check shall be payable directly to the contractor by the applicant. The commissioner may agree to a reasonable fingerprinting fee to be charged by the contractor.

(3) The commissioner shall treat and maintain an applicant's fingerprints and any criminal history record information obtained pursuant to this Section as confidential, shall apply security measures consistent with the Criminal Justice Information Services Division of the Federal Bureau of Investigation standards for the electronic storage of fingerprints and necessary identifying information, and shall limit the use of records solely to the purposes authorized in this Section. The fingerprints and any criminal history record information shall be exempt from the Public Records Law, R.S. 44:1 et seq., shall not be subject to subpoena, other than a subpoena issued in a criminal proceeding or investigation, shall be confidential by law and privileged, and shall not be subject to discovery or admissible in evidence in any private civil action.

E. (1) A navigator may:

(a) Provide fair and impartial information and services in connection with eligibility, enrollment, and program specifications of any health benefit plan issued or issued for delivery in this state, including information about the costs of coverage, advanced payment of premium tax credits, and cost sharing reductions.

(b) Facilitate the selection of a health benefit plan offered for sale on an exchange.

(c) Initiate the enrollment process for a health benefit plan offered for sale on an exchange.

(d) Provide referrals to the Department of Insurance or other local, state, or federal offices or agencies for any grievance, complaint, or inquiry in connection

with a health benefit plan or health insurance issuer, including a health maintenance organization.

(e) Carry out any activities required or authorized pursuant to 42 U.S.C. § 18031(i).

(2) Non-navigator personnel may carry out the functions and duties authorized for non-navigator personnel under 45 CFR Part 155 and shall:

(a) Disclose all conflicts of interest that the non-navigator personnel may have with health insurance issuers to enrollees and potential enrollees in a health benefit plan.

(b) Not receive any form of compensation, whether direct or indirect, from a health insurance issuer or an issuer of health stop loss insurance if prohibited by federal law.

(c) Not disclose any information obtained in the course of non-navigator personnel activities where such information is confidential or protected from disclosure by law.

F. Unless an individual navigator or non-navigator personnel possesses an accident and health insurance producer license, no navigator or non-navigator personnel shall:

(1) Sell, solicit, or negotiate a health benefit plan or any form of accident and health insurance.

(2) Engage in any activity that would exclusively require an insurance producer license.

(3) Provide partial advice concerning the benefits, terms, and features of health benefit plans or offer advice about which health benefit plan, health insurance issuer, or health maintenance organization is better or worse for a particular individual or employer.

(4) Recommend or endorse a particular health benefit plan or health insurance issuer or health maintenance organization.

(5) Provide any plan specific or product specific information or services related to any health benefit plan issued or issued for delivery in this state if such health benefit plan is not offered for sale on an exchange.

(6) Disclose any information obtained in the course of navigator activities where such information is confidential or protected from disclosure by law.

(7) Violate any of the provisions of 45 CFR 155.260 or other state or federal laws or regulations.

G. (1) The commissioner may place on probation, suspend, revoke, or refuse to issue, renew, or reinstate a navigator license, levy a fine not to exceed five hundred dollars for each violation, or take any combination of actions for any one or more violations of this Section or R.S. 22:1554 or for other good cause.

(2) The commissioner may examine and investigate the business affairs and records of any navigator to determine whether the individual or entity has engaged or is engaging in any violation of the provisions of this Section.

(3) A navigator entity license 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 that an individual navigator licensee's violation was known or should have been known by the employing or supervising entity and the violation was not reported to the commissioner on a timely basis.

(4) In the event that the commissioner suspends or revokes a navigator license, 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, in accordance and compliance with R.S. 49:961, shall notify the licensee in writing of the determination. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

H. (1) An individual navigator shall report to the commissioner any administrative action taken by a governmental agency against him in any jurisdiction within thirty calendar days of the final disposition of the matter. This report shall include a copy of the order or other relevant legal documents.

(2) Within thirty days of the initial pretrial hearing date, an individual navigator shall report to the commissioner any criminal prosecution of the navigator instituted in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(3) An entity that acts as a navigator that terminates the employment, engagement, affiliation, or other relationship with an individual navigator shall notify the commissioner within thirty days following the effective date of the termination, using a format prescribed by the commissioner, if the reason for termination is one of the reasons set forth in R.S. 22:1554 or the entity has knowledge that the individual navigator was found by a court or governmental agency to have engaged in any of the activities set forth in R.S. 22:1554. Upon the written request of the commissioner, the entity shall provide additional information, documents, records, or other data pertaining to the termination or activity of the individual navigator.

I. The provisions of R.S. 22:1964 and any related rules or regulations shall apply to navigators. The activities and duties of navigators shall be deemed to constitute transacting the business of insurance.

J. A navigator that is required to file annual and quarterly progress reports or annual financial reports with the Centers for Medicare and Medicaid Services shall also file such reports with the commissioner within fifteen days of filing with the appropriate federal office or agency.

K. The commissioner may promulgate such rules and regulations as may be necessary or 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, R.S. 49:950 et seq.

L. The commissioner may, in addition to his enforcement discretion, establish an enforcement moratorium for the provisions of this Section relating to the license requirement for navigators, the registration process for non-navigator personnel, and any prescribed training, education, or examinations for the purposes of properly effectuating the provisions of this Section.

Added by Acts 2014, No. 635, § 1, eff. June 12, 2014.

Severability—Acts 2014, No. 635

Section 4 of Acts 2014, No. 635 provides:

"Section 4. If any provision or provisions of this Act or its application to a particular circumstance is held to be invalid by a court of competent jurisdiction, the invalidity does not affect the other provisions or applications of this Act. A court of competent jurisdiction shall properly sever provisions that are held to be invalid, and the valid portions, provisions, or applications shall retain full force and effect."

§ 1567. Producers' compensation in form of fees; commercial property and casualty insurance; criteria for policyholders

Notwithstanding any other provision of law to the contrary, an insurance producer may negotiate with both or either a property and casualty insurer or a commercial policyholder, including a governmental entity pursuant to R.S. 42:1123(37)(b), to compensate the insurance producer for the placement of commercial property and casualty insurance coverages by any combination of commissions, fees, or fees in lieu of commissions if the commercial insurance policyholder, including a governmental entity pursuant to R.S. 42:1123(37)(b), meets one of the following criteria:

(1) Has total annual property and casualty insurance premiums in excess of five hundred thousand dollars.

(2) Obtains insurance coverage with a per occurrence or per claim deductible or self-insured retention of fifty thousand dollars or more for workers' compensation, general liability, or automobile insurance coverages.

(3) Has a net worth in excess of twenty-five million dollars.

(4) Qualifies as a self-insurer with the state of Louisiana.

(5) Is a governmental entity that had a contract prior to August 9, 2010, with an insurance producer on a stipulated fee basis for the placement of commercial property and casualty insurance coverages.

Added by Acts 2011, No. 9, § 1.

§ 1568. Producer compensation for sales of health and welfare plans

A. A health insurance issuer shall establish one or more schedules of commission for the sale of each health insurance product by an insurance producer. Such schedules of commission shall be uniformly applied to all producers within the

same schedule and shall be payable to all insurance producers licensed and appointed to sell the health insurance products of the issuer. The provisions of this Subsection shall not apply to any employee welfare benefit plan exclusively regulated by the United States Department of Labor pursuant to Section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, or Section 4 of the same act, 29 U.S.C. 1003.

B. In addition to a commission for a health insurance product, a health insurance producer may negotiate a charge, fee, or any other form of compensation directly with the plan sponsor or employer group.

C. Each health insurance contract entered into prior to June 14, 2013, shall comply with the provisions of this Section at the annual anniversary or renewal date following June 14, 2013. This Section shall apply to political subdivisions as defined by R.S. 42:1102, except for any political subdivision that had a contract on June 14, 2013 with an insurance producer or health insurance plan on a net of commission or stipulated fee basis for the placement of group health insurance coverage.

Added by Acts 2013, No. 283, § 1, eff. June 14, 2013.

SUBPART B. PRELICENSE AND CONTINUING EDUCATION PROGRAMS

§ 1571. Registered insurance producer and bail bond producer prelicensing program

A. (1) The commissioner shall certify an educational program that meets the requirements of this Subpart and any rules or regulations promulgated pursuant to this Subpart as a registered insurance producer or bail bond producer prelicensing program. Any person who satisfactorily completes an educational program which has been certified as a registered insurance producer or bail bond producer prelicensing program pursuant to this Subpart shall satisfy the preexamination educational requirements of R.S. 22:1571(E).

(2) For purposes of this Subpart, "bail bond producer" shall mean any person, corporation, or partnership which holds an insurance license and has a contract and an appointment from an insurer 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 or bail bond producer prelicensing program and for the procedure for certification of an instructional program as a registered insurance producer or bail bond producer prelicensing program. The commissioner shall also promulgate rules and regulations specifying the qualifications which each instructor in a registered insurance producer or bail bond producer 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 producer or bail bond producer 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.

(4) An organization recommended by and certified by the commissioner of insurance.

D. Each instructor in a registered insurance producer or bail bond producer prelicensing program shall possess the qualifications promulgated by the commissioner of insurance for instructors in such programs.

E. (1) Each registered insurance producer or bail bond producer prelicensing program shall provide instruction by a qualified instructor in a structured setting or by verifiable approved self-study with a minimum of twenty hours of supervised instruction or self-study, including instruction in applicable insurance principles, state laws and regulations, and ethical practices, for each of the following lines of authority a license is sought: life, health and accident, property, casualty, and personal lines.

(2) Each registered bail bond producer 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 producer or bail bond producer prelicensing program, the instructor shall permit the commissioner or 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. No information or materials shall be used for any personal reasons or gain.

G. The director or supervisor of each registered insurance producer or bail bond producer 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. In accordance and compliance with R.S. 49:961, the commissioner may cancel or suspend the certification of any registered insurance or bail bond producer prelicensing program which does not meet the requirements of this Subpart or of any of the rules or regulations promulgated pursuant to this Subpart. Such cancellation or suspension shall be made after notice and an opportunity for hearing. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1191 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1988, No. 840, § 1, eff. July 18, 1988 (and May 1, 1989). Amended by Acts 1992, No. 1039, § 1; Acts 1993, No. 142, § 1; Acts 1993, No. 952, § 4, eff. Jan. 1, 1994; Acts 2009, No. 317, § 1; Acts 2009, No. 485, § 1, eff. Jan. 1, 2010; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1572. Repealed by Acts 2009, No. 485, § 3, eff. Jan. 1, 2010

§ 1573. Continuing education requirements

A. The continuing education requirements for renewal of license under R.S.

22:1547(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 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. 22:1571(C).

C. Life insurance producers and health insurance producers shall complete twenty-four hours of approved instruction or verifiable approved self-study prior to each renewal of license, with at least three hours dedicated to the subject of ethics.

D. Insurance producers authorized to write property, casualty, or property and casualty or personal lines insurance business shall complete twenty-four hours of approved instruction or verifiable approved self-study before each renewal of license with at least three hours of approved instruction dedicated to the subject of ethics.

E. For producers authorized to write life, health and accident insurance and also authorized to write property, casualty, or property and casualty or personal lines insurance business, the continuing education requirement for renewal of license shall be twenty-four hours of approved instruction or verifiable approved self-study with at least three hours of approved instruction or verifiable approved self-study dedicated to the subject of ethics.

F. For bail bond producers, the continuing education requirement for renewal of license shall be twelve hours of approved bail underwriting instruction.

G. No more than ten excess hours of approved life and health and accident insurance instruction accumulated during one 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) 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 on January 1, 2012, who has at least fifteen years of experience as a licensed producer and who either:

(a) Is no longer actively engaged in the insurance business as a producer and who is receiving social security benefits, if eligible.

(b) Is actively engaged in the insurance business as a producer and who represents or operates through a licensed Louisiana insurer.

(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 Subparagraph (1)(a) of this Subsection shall apply only to a person who retires on or after January 1, 1994.

J. The commissioner may grant continuing education credits to any of the following:

(1) A licensed producer who participates in a qualified graduate-level national designation program, passes the test required of such program, and earns a certificate of completion. Qualified graduate-level national designation programs include programs in which a person may be designated as a Chartered Life Underwriter (CLU), Chartered Property Casualty Underwriter (CPCU), Certified Insurance Counselor (CIC), and other such national professional designations.

(2) A licensed producer who is a member of, and actively participates in, a state or national insurance association. The continuing education credits shall not exceed four hours.

K. The commissioner shall grant twenty-four continuing education credits to a licensed producer who is a member of the legislature while that person is serving a term in the legislature.

L. Beginning with license renewals effective in 2015, title insurance producers licensed pursuant to Subpart R of Part 1 of Chapter 2 of this Title, R.S. 22:511 et seq., shall complete twelve hours of approved instruction or verifiable approved self-study prior to the renewal of the license with at least two hours dedicated to matters related to state and federal consumer finance protection laws.

M. Any property and casualty insurance producer, upon receiving his initial license, shall complete three hours of approved instruction dedicated to flood insurance on his first license renewal when continuing education is required.

Renumbered from R.S. 22:1193 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 428, § 1. Amended by 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. 379, § 1; Acts 2006, No. 522, § 1; Acts 2009, No. 485, § 1, eff. Jan. 1, 2010; Acts 2010, No. 967, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2013, No. 21, § 1; Acts 2014, No. 83, § 1.

§ 1574. Bail Bond Apprentice Program

A. (1) The Bail Bond Apprentice Program is hereby created.

(2) The Bail Bond Apprentice Program shall be available only to persons who meet current bail bond producer licensing requirements as provided for in Chapter 5 of this Title and who have not been convicted of a felony.

(3) All persons entering the Bail Bond Apprentice Program shall register with the commissioner of insurance at least ten days prior to beginning the program. Registration shall consist of filing with the commissioner a properly completed form prescribed by the commissioner. The information required on such form from each apprentice shall include but shall not be limited to each of the following:

(a) The name, home address, and telephone number of the registrant.

(b) The date of birth and social security number of the registrant.

(c) The date the prospective apprentice shall commence training in the Bail Bond Apprentice Program.

(d) The name, address, and license number of the supervising licensed bail bond producer.

(4) Apprentices shall complete the registered insurance producer and bail bond producer prelicensing program as provided for in R.S. 22:1571 before the end of the apprenticeship program.

B. The Bail Bond Apprentice Program shall consist of three consecutive months of employment by a Department of Insurance licensed bail bond producer. The apprentice shall be supervised by the producer during the three-month period and work for no less than twenty-four hours per week. The apprentice shall observe the bail bond producer, perform every phase of the bail bond business, and shall perform duties in every phase of the bail bond business except for the solicitation, negotiation, quotation of fees, and the execution of a bail bond.

C. The supervising bail bond producer shall maintain records to support that the apprentice has worked the required number of hours. For each apprentice, these records shall include pay stubs and time sheets. Time sheets shall contain the number of hours worked, the specific functions performed, and the date and time of the performance of those functions. These records shall be made available for examination and review to the Department of Insurance upon request.

D. (1) Upon completion of the required three months of work experience, without expulsion, the apprentice and the supervising bail bond producer shall certify, on a form provided by the Department of Insurance, that the apprentice has completed all of the requirements of the apprentice program. This form shall be a notarized sworn affidavit, completed under penalty of perjury.

(2) No person shall be permitted to sit for an examination as a bail bond producer until completion of this apprenticeship program and until the required certification of the completion has been submitted to the Department of Insurance along with the required application for testing and licensure.

E. The program created by the provisions of this Section shall be subject to the provisions of this Title, and nothing in this Section shall be interpreted to permit the payment of commissions to an unlicensed producer.

Added by Acts 2010, No. 731, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2012, No. 89, § 1.

§ 1575. Producer training requirements to sell long-term care insurance

A. (1) An individual shall not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for health and accident or life and has completed a one-time training course. The training shall meet the requirements set forth in Subsection B of this Section.

(2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on August 15, 2010 may not continue to sell, solicit or negotiate long-term care insurance unless the individual has completed a one-time training course as set forth in Subsection B of this Section within one year from August 15, 2010.

(3) In addition to the one-time training course required in Paragraphs (1) and (2) of this Subsection, an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in Subsection B of this Section.

(4) The training requirements of Subsection B of this Section may be approved as continuing education courses under R.S. 22:1573.

B. (1) The one-time training required by this Section shall be no less than eight hours and the ongoing training required by this Section shall be no less than four hours every two years.

(2) The training required under Paragraph (1) of this Subsection shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance partnership programs, including but not limited to:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid.

(b) Available long-term services and providers.

(c) Changes or improvements in long-term care services or providers.

(d) Alternatives to the purchase of private long-term care insurance.

(e) The effect of inflation on benefits and the importance of inflation protection.

(f) Consumer suitability standards and guidelines.

(3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

C. (1) Insurers shall obtain verification that a producer receives training required by Subsection A of this Section before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make such

verification available to the commissioner upon request.

(2) Insurers shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subparagraph (B)(2)(a) of this Section as required by Subsection A of this Section and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.

D. The satisfaction of such training requirements in any state shall be deemed to satisfy the training requirements in this state.

Added by Acts 2010, No. 967, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1576. Producer training requirements to sell annuity products

A. An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of such annuity product to make a recommendation and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with the requirements of this Subsection.

B. (1)(a) An insurance producer who engages in the sale of annuity products shall complete a one-time four-credit training course approved by the Department of Insurance and provided by an educator who has been approved by the Department of Insurance.

(b) Insurance producers who hold a life insurance line of authority on August 15, 2012, and who desire to sell annuities shall complete the requirement of this Subsection no later than January 1, 2013. An individual who holds a life insurance line of authority and has satisfied the training requirements in another state with substantially similar requirements prior to January 1, 2013, shall be deemed to have satisfied the training requirements of this state. Individuals who obtain a life insurance line of authority on or after August 15, 2012, may not engage in the sale of annuities until the annuity training course required pursuant to this Subsection has been completed.

(2) The minimum length of the training required pursuant to this Subsection shall be sufficient to qualify for at least four continuing education credits, but may be longer.

(3) The training required pursuant to this Subsection shall include information on the following topics:

(a) The types of annuities and various classifications of annuities.

(b) Identification of the parties to an annuity.

(c) A description of how fixed, variable, and indexed annuity contract provisions affect consumers.

(d) The application of income taxation of qualified and nonqualified annuities.

(e) The primary use of annuities.

(f) Appropriate sales practices, replacement, and disclosure requirements.

(4) Providers of courses intended to comply with this Subsection shall cover all topics listed in Paragraph (3) of this Subsection and shall not present any marketing information or provide training on sales techniques or specific information about a particular insurer's products. Additional topics may be offered in addition to the topics required by this Subsection.

(5) A provider of an annuity training course intended to comply with this Subsection shall register as a continuing education provider in this state and shall comply with the rules and guidelines applicable to insurance producer continuing education courses pursuant to LAC 37:XI.701 et seq.

(6) Annuity training courses may be conducted and completed by classroom or by verifiable self-study methods pursuant to LAC 37:XI.701 et seq.

(7) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion pursuant to LAC 37:XI.701 et seq.

(8) The satisfaction of the training requirements of another state which has standards which are substantially similar to the provisions of this Subsection shall be deemed to satisfy the training requirements of this Subsection in this state.

(9) An insurer shall verify that an insurance producer has completed the annuity training course required by this Subsection before allowing the insurance producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this Paragraph by obtaining certificates of completion of the training course by the insurance producer or by obtaining reports provided by commissioner database systems.

Added by Acts 2012, No. 612, § 1.

SUBPART C. BAIL ENFORCEMENT AGENTS

§ 1581. 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 Subpart 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.

Renumbered from R.S. 22:1514 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1037, § 1.

§ 1582. Definitions

As used in this Subpart:

(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.

Renumbered from R.S. 22:1514.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1037, § 1.

§ 1583. Licensing and fees

Except as provided by the regulations authorized in this Subpart, bail enforcement agents shall be subject to the same licensing and fee requirements as bail bond producers.

Renumbered from R.S. 22:1514.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1037, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1584. Bail 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 Paragraphs (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.

Renumbered from R.S. 22:1514.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 223, § 1, eff. June 5, 2003. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1585. 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 or if the defendant is convicted of a felony but sentence is not yet imposed. 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___.

_____

<COL>Surety/Bail Bond Producer/Agent of Surety or

<COL>Bail Bond Producer

C. Upon first violation, a bail bond producer who surrenders a client for nonpayment of a premium in violation of this Section 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.

Renumbered from R.S. 22:1514.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1194, § 1, eff. July 3, 2003. Amended by Acts 2010, No. 914, § 4; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

SUBPART D. FINANCIAL INSTITUTION SALES

§ 1591. Short title

This Subpart may be cited as the "Financial Institution Insurance Sales Law".

Renumbered from R.S. 22:3051 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1592. Purpose

The legislature hereby declares that the purpose of this Subpart is to regulate the business of insurance in Louisiana and to protect the interests of insurance policyholders in this state.

Renumbered from R.S. 22:3052 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011,

No. 94, § 1, eff. Jan. 1, 2012.

§ 1593. Definitions

A. For the purposes of this Subpart:

(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 producer 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.

Renumbered from R.S. 22:3053 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2004, No. 350, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1594. Applicability

The provisions of this Subpart 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 allied lines as defined in R.S. 22:47 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.

Renumbered from R.S. 22:3053.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 350, § 1. Amended by Acts 2009, No. 326, § 1, eff. Jan.

1, 2010; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1595. 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 [1] as may be necessary to effectuate the provisions of this Subpart. However, the commissioner of insurance shall not impose any additional requirement on any insurance producer who is associated with a financial institution that is not imposed on any insurance producer who is not associated with such institution unless such requirement is set forth in this Subpart.

Renumbered from R.S. 22:3054 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

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

§ 1596. 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.

Renumbered from R.S. 22:3055 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997.

§ 1597. 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 Subpart, solicitation does not include referral of the customer to a licensed insurance producer 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. 22:1600.

Renumbered from R.S. 22:3056 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1598. 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. Any person or entity responsible for making a specific loan or extension of credit may receive a reasonable referral fee for the insurance referral of a customer who is required to provide insurance for that loan or extension of credit. An insurance referral fee paid to such person or entity making a specific loan or extension of credit shall not be in the form of an insurance sales commission which varies based on the quotation or application for insurance, purchase of insurance, or the amount of premium written. The insurance referral fee shall be paid solely on the basis of the referral. This Section shall not preclude a person directly or indirectly responsible for making a specific loan or extension of credit, who is a licensed insurance producer, from soliciting and selling insurance to a loan customer and earning a commission, so long as the solicitation and sale is conducted after the final loan decision has been communicated to the customer in writing, in accordance with the provisions of R.S. 22:1597. The customer shall also be notified that he 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.

Renumbered from R.S. 22:3057 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2009, No. 332, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1599. 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 provisions of this Subpart, 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 Subpart 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.

Renumbered from R.S. 22:3058 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1600. Disclosure; 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) Repealed by Acts 2004, No. 350, § 2.

(2) Repealed by Acts 2004, No. 350, § 2.

(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 disclosure 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.

Renumbered from R.S. 22:3059 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1601. 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.

Renumbered from R.S. 22:3060 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997.

§ 1602. 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.

Renumbered from R.S. 22:3061 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997.

§ 1603. No discrimination against non-affiliated producers

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 producer.

(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 producer who is not associated with the financial institution that is not imposed on any insurance producer who is associated with such institution.

Renumbered from R.S. 22:3062 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1604. 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 producer 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 producer 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.

Renumbered from R.S. 22:3063 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1605. Unfair trade practice

Failure to comply with any of the provisions of this Subpart 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. 22:1554 and 1967 through 1972.

Renumbered from R.S. 22:3065 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1475, § 2, eff. July 15, 1997. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

PART II. MANAGING GENERAL AGENT

§ 1621. Title

This Part shall be known and may be cited as the "Managing General Agents Law".

Renumbered from R.S. 22:1201 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. August 21, 1992.

§ 1622. Definitions

As used in this Part, unless the context requires otherwise, the following definitions shall be applicable:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(2) "Commissioner" means the commissioner of insurance as defined in R.S. 22:46.

(3) "Insurer" means any person duly licensed in this state as an insurer pursuant to this Chapter.

(4)(a) "Managing General Agent" (MGA) means any person 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:

(i) Adjusts or pays claims in excess of an amount determined by the commissioner.

(ii) Negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding the preceding provisions of this Subsection, the following persons shall not be considered as MGAs for the purposes of this Part:

(i) An employee of the insurer.

(ii) A United States manager of the United States branch of an alien insurer.

(iii) 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 Insurance Holding Company System Regulatory Law, R.S. 22:691 et seq. and whose compensation is not based on the volume of premiums written.

(iv) The attorney authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

(5) "Person" shall have the same meaning as set forth in R.S. 22:1542.

(6) "Producer" or "insurance producer" means a person currently licensed as a property and casualty producer 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 in this Part.

(7) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

Renumbered from R.S. 22:1202 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. Aug. 21, 1992. Amended by Acts 1993, No. 189, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1623. Licensure; registration

A. No person 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 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 shall act in the capacity of an MGA in this state unless such person 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. 22:821.

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. 22:821.

F. If a person fails to provide any of the information required pursuant to this Section, the commissioner may, after notification by the commissioner to the person 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.

Renumbered from R.S. 22:1203 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. Aug. 21, 1992. Amended by Acts 1991, No. 736, § 1; Acts 1993, No. 189, § 1; Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1624. Required contract provisions

A. No person 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:

(1) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA while any dispute regarding the cause for termination is pending.

(2) 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.

(3) 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 Deposit Insurance Corporation (FDIC). 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.

(4) 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.

(5) The contract may not be assigned in whole or part by the MGA.

(6) Appropriate underwriting guidelines including:

(a) The maximum annual premium volume.

(b) The basis of the rates to be charged.

(c) The types of risks which may be written.

(d) Maximum limits of liability.

(e) Applicable exclusions.

(f) Territorial limitations.

(g) Policy cancellation provisions.

(h) The maximum policy period.

(7) The insurer shall have the right to cancel or nonrenew any policy of insurance pursuant to the laws and regulations applicable thereto.

(8) If the contract permits the MGA to settle claims on behalf of the insurer:

(a) All claims shall be reported to the insurer in a timely manner.

(b) 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 meets at least one of the following criteria:

(i) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less.

(ii) Involves a coverage dispute.

(iii) May exceed the MGA's claims settlement authority.

(iv) Is open for more than six months.

(v) Is closed by payment of an amount set by the commissioner or an amount set by the insurer, whichever is less.

(c) 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.

(d) 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.

(9) When electronic claims files are in existence, the contract shall address the timely transmission of the data.

(10) 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. 22:1625.

B. 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.

Renumbered from R.S. 22:1204 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. Aug. 21, 1992. Amended by Acts 1993, No. 189, § 1; Acts 2009, No. 332, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1625. 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 insurer'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 information the commissioner may request. A fee in the amount set forth in R.S. 22:821 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. 22:1622(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. 22:821.

H. All such appointments shall remain in full force and effect until April thirtieth of the following year unless:

(1) The producer license of the MGA is revoked or suspended by the commissioner as provided for in this Part or as prescribed in R.S. 22:1554.

(2) The insurer has cancelled the appointment upon written notice to the producer 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. 22:691 et seq., or, if applicable, R.S. 22:1621 et seq.

Renumbered from R.S. 22:1205 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. Aug. 21, 1992. Amended by Acts 1993, No. 189, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1626. 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.

Renumbered from R.S. 22:1206 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. August 21, 1992.

§ 1627. Penalties; suspension, revocation, fines, and liabilities

A. If the commissioner finds after a hearing conducted in accordance with the Administrative Procedure Act, R.S. 49:950 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 license of the MGA.

(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 Chapter 12 of this Title, R.S. 22:2191 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.

Renumbered from R.S. 22:1207 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 265, § 1, eff. Aug. 21, 1992. Amended by Acts 1993, No. 189, § 1; Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§§ 1628 to 1640. Reserved for future legislation

PART III. THIRD-PARTY ADMINISTRATORS

§ 1641. Definitions

As used in this Part, unless the context requires otherwise, the following definitions shall be applicable:

(1) "Administrator" or "third-party administrator" or "TPA" means any 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 plans of self-insurance providing accident and health protection or self-insurance of workers' compensation coverage, or any individual, partnership, corporation, or other person who contracts directly or indirectly with a group self-insurance fund licensed pursuant to the provisions of R.S. 23:1195 et seq. to provide claims adjusting, underwriting, safety engineering, loss control, marketing, investment advisory, or administrative services to the fund or its membership, other than bookkeeping, auditing, or claims investigation services, 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 insurance producer licensed to sell life or health insurance in this state, whose activities are limited exclusively to the sale of insurance.

(d) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(e) A trust and its trustees, agents, and employees acting pursuant to such trust established in conformity with 29 U.S.C. 186.

(f) 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.

(g) 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 producers or authorized insurers in connection with loan payments.

(h) 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.

(i) 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.

(j) 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 (29 U.S.C. 1001 et seq.).

(k) 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" means as defined in R.S. 22:692[1].

(5) "Insurance" or "insurance coverage" means any coverage offered or provided by an insurer. For the purposes of this Part, the term shall also mean any coverage for workers' 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 workers' compensation insurance in this state. For the purposes of this Part, 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) "Person" shall have the same meaning as set forth in R.S. 22:1542.

(8) "Pharmacy benefit manager" means a person, business, or other entity and any wholly or partially owned or controlled subsidiary of such entity that administers the prescription drug or device portion of one or more health benefit plans on behalf of a third party, including plan sponsors, insurance companies, unions, and health maintenance organizations, in accordance with a pharmacy benefit management plan.

(9) "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.

Renumbered from R.S. 22:3031 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2009, No. 99, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 1642. 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, unless 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 while any dispute regarding the cause for termination of the written agreement is pending. 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.

Renumbered from R.S. 22:3032 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1643. 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.

Renumbered from R.S. 22:3033 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1644. 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 in this Part, 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 in this Part.

Renumbered from R.S. 22:3034 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1645. 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.

Renumbered from R.S. 22:3035 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1646. 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.

Renumbered from R.S. 22:3036 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1647. 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.

Renumbered from R.S. 22:3037 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1648. 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.

Renumbered from R.S. 22:3038 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1649. 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.

Renumbered from R.S. 22:3039 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1650. 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.

Renumbered from R.S. 22:3040 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1651. 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. 22:821 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 Part.

(6) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an insurance producer 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 producer shall provide proof that he has a license as an insurance producer 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 in this Part, 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 Part.

F. An administrator is not required to hold a license as an administrator in this state if the administrator is an insurer which is authorized to transact the business of insurance in this state or 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. Repealed by Acts 2009, No. 99, § 2.

H. A licensed administrator shall notify the commissioner of any material change in fact or circumstance affecting its qualification for a license in this state within sixty days of the effective date of the change. The notice shall include any documentation as the commissioner may require. Changes in fact or circumstances shall include:

(1) Changes in control.

(2) Amendments to the articles of incorporation.

(3) Changes in officers and directors.

(4) Merger or consolidation of the administrator with any other person or entity.

(5) Entering into any contract with an insurer where residents of this state are included.

(6) Use of a trade name in this state.

I. (1) A licensed 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 surety bond in accordance with the provisions of R.S. 23:1196(C), 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.).

(3) If the provisions of this Subsection are met with a surety bond, the administrator shall provide annually to the commissioner evidence that the surety bond continues in full force and effect. This notice shall be provided no less than ten days prior to the expiration or anniversary date of the surety bond.

Renumbered from R.S. 22:3041 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 2004, No. 372, § 1; Acts 2009, No. 99, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1652. Waiver of application for certification

Upon request from an administrator, the commissioner may waive the application requirements in this Part 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.

Renumbered from R.S. 22:3042 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1653. 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. 22:821.

Renumbered from R.S. 22:3043 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1993, No. 144, § 1.

§ 1654. Grounds for suspension or revocation of license

A. The commissioner shall suspend or revoke, or in lieu of revocation, impose a fine for each separate violation not to exceed five thousand dollars per violation or twenty-five thousand dollars in the aggregate if he 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 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.

Renumbered from R.S. 22:3044 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 1996, 1st Ex.Sess., No. 71, § 1, eff. May 10, 1996; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1655. Rules and regulations

The commissioner may adopt those rules and regulations as are necessary to implement this Chapter.

Renumbered from R.S. 22:3045 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1.

§ 1656. Confidentiality; documents, information

The terms and conditions of any contract between an administrator and an insurer, except for the identity of the contracting parties, and such other proprietary information as specifically identified by the administrator 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.

Renumbered from R.S. 22:3046 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 144, § 1. Amended by Acts 2009, No. 99, § 1.

§ 1657. Pharmacy benefit managers

A pharmacy benefit manager shall be deemed to be a third-party administrator for purposes of this Part. As such, all provisions of this Part shall apply to pharmacy benefit managers; however, notwithstanding the provisions of R.S. 22:1651(F), every pharmacy benefit manager shall be required to be licensed by the commissioner of insurance.

Added by Acts 2008, No. 386, § 1, eff. Jan. 1, 2009. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

PART IV. CLAIMS ADJUSTERS

§ 1661. Definitions

As used in this Part, unless the context requires otherwise, the following definitions shall be applicable:

(1) "Adjuster" means an individual who investigates or adjusts losses on behalf of an insurer as an independent contractor or as an employee of:

(a) An adjustment bureau;

(b) An association;

(c) A property and casualty producer;

(d) An independent contractor;

(e) An insurer; or

(f) A managing general agent.

(2) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(3) "Fingerprints" means an impression of the lines on the finger taken for purpose of identification. The impression may be electronic or in ink converted to electronic format.

(4) "Home state" means the District of Columbia and any state or territory of the United States in which the adjuster's principal place of residence or principal place of business is located. If neither the state in which the adjuster maintains the principal place of residence nor the state in which the adjuster maintains the principal place of business has a substantially similar law governing adjusters, the adjuster may declare another state in which he becomes licensed and acts as an adjuster to be the "home state".

(5) "Individual" means a natural person.

(6) "Insurer" means any type of insurer, whether authorized or unauthorized, conducting business in this state.

(7) "Person" means an individual or a business entity.

(8) "Uniform individual application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Individual Application for resident and nonresident individuals.

(9) "Uniform business entity application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities.

Renumbered from R.S. 22:1210.71 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2015, No. 193, § 1.

§ 1662. General exemptions

This Part does not apply to:

(1) An attorney at law admitted to practice in this state, when acting in his professional capacity as an attorney.

(2) An employee of an insurer who is not regularly engaged in the adjustment or investigation of insurance claims.

(3) A person employed only to furnish technical assistance to a licensed adjuster, including but not limited to an investigator, an attorney, an engineer, an estimator, a handwriting expert, a photographer, and a private detective.

(4) A producer of an authorized insurer or a licensed employee of a producer who processes an undisputed or uncontested loss for the insurer under a policy issued by the producer.

(5) A person who performs clerical duties and does not negotiate with parties on disputed or contested claims.

(6)(a) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry including entering data into an automated claims adjudication system if such individual is an employee of a business entity licensed pursuant to this Chapter, or an employee of an affiliate of a business entity licensed pursuant to the Chapter, if there are no more than twenty-five individuals under the supervision of one licensed individual adjuster or licensed individual insurance producer. As used in this Part, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and system generated final resolution of consumer electronic products insurance claims which:

(i) May be utilized only by a licensed adjuster or licensed producer, or supervised individuals operating pursuant to this Paragraph;

(ii) Must comply with all claims payment requirements of the Louisiana Insurance Code; and

(iii) Must be certified as compliant with this Section by a licensed adjuster that is an officer of a licensed business entity under this Chapter.

(b) Individuals who are licensed as producers pursuant to R.S. 22:1543 are not required to be licensed as an adjuster for purposes of this Section.

(7) A person who handles claims arising under life, accident, and health insurance policies.

(8) A person who is employed principally as a right-of-way agent or a right-of-way and claims agent whose primary responsibility is the acquisition of servitudes, leases, permits, or other real property rights and who handles only claims arising out of operations under those servitudes, leases, permits, or other contracts or contractual obligations.

(9) An individual who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine claims payments.

(10) A full-time salaried employee of a property owner or a property management company retained by a property owner who either does not hold the employee out as an insurance adjuster or who has not been hired to handle a specific claim resulting from a fire or casualty loss and who acts at the sole discretion of the property owner or management company regarding a claim related to the owner's property.

(11) A person who handles claims arising under vehicle mechanical breakdown insurance policies as defined in R.S. 22:361.

(12) A person who handles claims arising under property residual value insurance policies as defined in R.S. 22:381.

(13) A person handling claims for workers' compensation benefits pursuant to Title 23 of the Louisiana Revised Statutes of 1950 or a person handling claims arising under a workers' compensation policy or group self insurers fund indemnity agreement.

(14) A person handling commercial claims for excess coverages as classified by R.S. 22:47.

(15) A person who settles only reinsurance or subrogation claims.

Renumbered from R.S. 22:1210.72 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2010, No. 1007, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1663. License required

A. A person shall not act or hold himself out as a claims adjuster in this state unless the person is licensed as a claims adjuster in accordance with this Part.

B. A business entity acting as a claims adjuster is required to obtain a claims adjuster license. Application shall be made using the uniform business entity application. Before approving the application, the commissioner of insurance shall find that:

(1) The business entity has paid the fees set forth in R.S. 22:821.

(2) The business entity has designated a licensed adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

Renumbered from R.S. 22:1210.73 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1664. Application for claims adjuster license

A. Any person who is either employed or contracts to perform services in Louisiana as an adjuster shall obtain a license to do so from the Department of Insurance. A person applying for a claims adjuster license shall make application to the commissioner of insurance on the appropriate uniform application or other application required by the commissioner of insurance.

B. The applicant shall declare under penalty of perjury and 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 applicant's knowledge and belief.

C. (1) In order to make a determination of eligibility, the commissioner of insurance is authorized to require fingerprints of applicants and submit the

fingerprints and the fee required to perform the criminal history record checks to the Louisiana Bureau of Criminal Identification and Information and the Federal Bureau of Investigation (FBI) for state and national criminal history record checks. The commissioner of insurance shall require a criminal history record check on each applicant in accordance with this Part. The commissioner of insurance shall require each applicant to submit a full set of fingerprints in order for the commissioner of insurance to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(2) All business entities applying to do business as independent adjusting companies shall provide a listing of all executive officers and directors of the applicant and of all executive officers and directors of entities owning and any individuals owning, directly or indirectly, ten percent or more of the outstanding voting securities of the applicant. In order to make a determination of eligibility, the commissioner may require any person listed pursuant to this Paragraph to submit addresses, social security numbers, criminal and administrative history, fingerprints, background checks, and biographical statements.

(3) The commissioner of insurance may contract for the collection, transmission, and resubmission of fingerprints required under this Section. If the commissioner of insurance does so, the fee for collecting, transmitting, and retaining fingerprints shall be payable directly to the contractor by the person. The commissioner of insurance may agree to a reasonable fingerprinting fee to be charged by the contractor.

(4) The commissioner of insurance may waive submission of fingerprints by any person that has previously furnished fingerprints and whose fingerprints are on file with the Central Repository of the National Association of Insurance Commissioners (NAIC), its affiliates, or subsidiaries.

(5) The commissioner of insurance is authorized to receive criminal history record information in lieu of the Louisiana Bureau of Criminal Identification and Information that submitted the fingerprints to the FBI.

(6) The commissioner of insurance is authorized to submit electronic fingerprint records and necessary identifying information to the National Association of Insurance Commissioners (NAIC), its affiliates, or subsidiaries for permanent retention in a centralized repository. The purpose of such a centralized repository is to provide insurance commissioners with access to fingerprint records in order to perform criminal history record checks.

Renumbered from R.S. 22:1210.74 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2010, No. 1007, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1665. Resident license

A. Before issuing a claims adjuster license to an applicant pursuant to this Section, the commissioner of insurance shall find that the applicant:

(1) Is eligible to designate this state as his home state or is a nonresident who is not eligible for a license pursuant to R.S. 22:1670.

(2) Has not committed any act that is a ground for denial, suspension, or revocation of a license as set forth in R.S. 22:1672.

(3) Has paid the fees set forth in R.S. 22:821.

(4) Maintains an office in the home state of residence with public access by reasonable appointment or regular business hours.

(5) 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. In addition to satisfying the requirements of Subsection A, an individual shall:

(1) Be at least eighteen years of age.

(2) Have successfully passed the adjuster examination unless exempted pursuant to R.S. 22:1669.

C. In addition to satisfying the requirements of Subsection A, a business entity shall:

(1) Designate a licensed individual claims adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state; and

(2) Designate only licensed individual claims adjusters to exercise the business entity's license.

D. No resident of Canada may be licensed pursuant to R.S. 22:1663, or may designate Louisiana as their home state, unless such person has successfully passed the adjuster examination and has complied with the other applicable portions of this Section, except that such applicant shall not be required to comply with Paragraph (A)(4) of this Section.

E. The commissioner of insurance may require any documents reasonably necessary to verify the information contained in the application.

Renumbered from R.S. 22:1210.75 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2010, No. 1007, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1666. Limited claims adjuster license

A. If considered necessary by the commissioner of insurance, the department may issue a limited claims adjuster license to an applicant in the manner otherwise provided for the issuance of a license under this Part.

B. The claims adjuster license shall specifically limit the kinds of insurance that may be handled by the person.

C. The claims adjuster shall not adjust insurance claims other than those for

which the adjuster is specifically licensed.

Renumbered from R.S. 22:1210.76 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1667. Catastrophe or emergency claims adjuster registration

A. In the event of a catastrophe or an emergency, no adjuster's license shall be required for an individual who is employed or retained by an insurer and brought into this state for the purpose of investigating or making adjustment of losses resulting from the catastrophe or emergency. Notwithstanding, the commissioner of insurance shall establish procedures to register all such individuals.

B. The commissioner of insurance may, without notice and hearing, revoke the privileges of an individual registered pursuant to this Section on grounds specified by R.S. 22:1672(A), and thereafter it shall be unlawful for any such person to adjust any such losses, claims, or damages in this state.

C. A catastrophe or emergency claims adjuster license shall be effective for a period not to exceed one hundred eighty days. The commissioner of insurance may extend the term for an additional period of ninety days.

D. The fee for the catastrophe or emergency registration shall be as set forth in R.S. 22:821 and shall be payable to the commissioner of insurance within ten days of the submission of the registration.

E. The registration requirements of this Section shall not apply to a producer of an insurer or a licensed employee of a producer that adjusts undisputed claims or losses under specific authority from the insurer and solely under policies issued by the insurer.

Renumbered from R.S. 22:1210.77 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1668. Claims adjuster license examination

A. An individual applying for a claims adjuster license under this Part shall pass a written examination unless exempt pursuant to R.S. 22:1669, 1670, or 1671. The examination shall test the knowledge of the individual concerning the duties and responsibilities of a claims adjuster 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. The commissioner of insurance may make arrangements, including contracting with one or more outside testing services for administering examinations and collecting the examination fees. The commissioner of insurance may require that the applicant pay the cost of the examination directly to the testing firm.

C. An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

Renumbered from R.S. 22:1210.78 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1669. Exemptions from examination

A. An individual who applies for a claims adjuster license in this state who was previously licensed as a claims adjuster in another state based on a claims adjuster examination shall not be required to complete an examination. This exemption is available only if the person is currently licensed in that state or if the application is received within twelve months of the cancellation of the applicant's previous claims adjuster 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 or records maintained by the National Association of Insurance Commissioners (NAIC), its affiliates, or subsidiaries, indicate that the adjuster is or was licensed in good standing.

B. An individual licensed as a claims adjuster in another state based on a claims adjuster examination who moves to this state shall make application within ninety days of establishing legal residence to become a resident claims adjuster licensee pursuant to R.S. 22:1665. No examination shall be required of that person to obtain a claims adjuster license.

C. An individual who applies for a claims adjuster license in this state who was previously licensed as a claims adjuster in this state shall not be required to complete an examination. This exemption is available only if the application is received within twelve months of the cancellation of the applicant's previous claims adjuster license in this state and if, at the time of cancellation, the applicant was in good standing in this state, and had passed the examination required by R.S. 22:1668.

Renumbered from R.S. 22:1210.79 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1670. Nonresident claims adjuster license reciprocity

A. Unless denied licensure pursuant to R.S. 22:1672, a nonresident person may receive a nonresident claims adjuster license upon complying with the following requirements:

(1) The person is currently licensed as a resident claims adjuster, and if an individual has passed a claims adjuster examination, and is in good standing in the home state. If the home state does not require examinations then the individual shall pass the examination provided for in R.S. 22:1668.

(2) The person has submitted the proper fees required by R.S.22:821.

(3) The person has submitted or transmitted to the commissioner of insurance the appropriate completed application for licensure.

(4) The person's home state awards nonresident claims adjuster licenses to residents of this state on the same basis.

B. The commissioner of insurance may verify the adjuster's licensing status

through the producer database maintained by the National Association of Insurance Commissioners (NAIC), its affiliates, or subsidiaries.

C. (1) The commissioner of insurance shall not issue a license to any nonresident applicant until such applicant has filed forms approved by the commissioner of insurance which designate the commissioner of insurance 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 business in this state. This 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.

(2) 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 as authorized by R.S. 22:821.

(3) 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 nonresident claims adjuster licensee at his last known address of record or principal place of business, and the commissioner of insurance shall maintain copies of all such processes so served upon him.

(4) The service of process upon any such nonresident claims adjuster licensee in any action or proceeding instituted by the commissioner of insurance under this Part shall be made by the commissioner of insurance 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.

D. As a condition to continuation of a nonresident claims adjuster license issued pursuant to this Section, the nonresident claims adjuster licensee shall maintain a resident adjuster license in his home state. The nonresident claims adjuster license issued pursuant to this Section shall terminate and be surrendered immediately to the commissioner of insurance if the home state claims adjuster license terminates for any reason, unless the claims adjuster has been issued a license as a resident claims adjuster in their new home state and the new home state awards nonresident claims adjuster licenses to residents of this state on the same basis. Notification to the state or states where a nonresident license is issued shall be made as soon as possible, yet no later than thirty days of change in the new state resident license. The licensee shall include his current and prior address.

Renumbered from R.S. 22:1210.80 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1671. License

A. Unless denied licensure pursuant to this Part, persons who have met the requirements of this Part shall be issued a claims adjuster license. The license shall contain the licensee's name, business address, license number, date of issuance, expiration date, and any other information the commissioner of insurance deems necessary.

B. (1) A claims adjuster license shall remain in effect unless revoked, terminated, suspended, or denied renewal or reinstatement, as long as the request for renewal has been filed, the fee set forth in R.S. 22:821 has been paid, and any other requirements for license renewal are met by the due date.

(2) Every licensed claims adjuster shall file an application for renewal of his license every two years, by notifying the commissioner of insurance using methods required by the commissioner of insurance, of the licensee's intention to continue his license.

C. The licensee shall inform the commissioner of insurance by any means acceptable to the commissioner of insurance of a change of address, change of legal name, or change of information submitted on the application within thirty days of the change. Failure to file a change within the required time shall subject the licensee to a fifty dollar fine per violation. 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 in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

D. A licensed claims adjuster shall be subject to R.S. 22:1961 et seq., relative to unfair trade practices, and R.S. 22:1921 et seq., relative to insurance fraud.

E. A claims adjuster whose license has lapsed may, within twelve months from the expiration date of the renewal, reinstate the license upon approval of the commissioner of insurance. However, a penalty in the amount of double the unpaid renewal fee shall be required for the reinstatement of the claims adjuster license. Reinstatement shall be effective on the date the commissioner of insurance approves the request for reinstatement.

F. A licensed claims adjuster who is unable to comply with license renewal procedures due to military service, long-term medical disability, or other extenuating circumstance, may request a waiver of those procedures. The licensed claims adjuster may also request a waiver of any examination requirement, fine, or other sanction imposed for failure to comply with renewal procedures.

G. To assist the commissioner of insurance in his licensing duties, he may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the National Association of Insurance Commissioners (NAIC) oversees to perform any ministerial functions, including the collection of fees and data, related to licensing that the commissioner of insurance may deem appropriate.

Renumbered from R.S. 22:1210.81 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1672. License denial, nonrenewal, or revocation

A. The commissioner of insurance may place on probation, suspend, revoke, or refuse to issue, renew, or reinstate a claims adjuster's license or may levy a fine not to exceed five hundred dollars for each violation up to ten thousand dollars aggregate for all violations in a calendar year, unless a fine is established by separate statute in this Title authorizing a greater penalty, or any combination of actions, for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially false information in the license application.

(2) Violating any state insurance law or regulation or a subpoena or order of the commissioner of insurance or of another state's insurance commissioner.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any money or property received in the course of conducting insurance business.

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(6) Conviction of a felony related to the adjustment of insurance claims.

(7) Admitting to or committing fraud or unfair trade practices.

(8) Using fraudulent, coercive, or dishonest practices.

(9) Demonstrating incompetence, untrustworthiness, or financial irresponsibility while conducting business.

(10) Denial, suspension, or revocation of an insurance license, or its equivalent, in any other state, province, district, or territory.

(11) Forging a name on an application for insurance or any document related to an insurance transaction.

(12) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license.

(13) Knowingly accepting insurance business from an individual who is not licensed but who is required to be licensed by the commissioner of insurance.

(14) Failure to comply with an administrative or court order imposing a child support obligation.

(15) Failure to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(16) Violating R.S. 22:1674(F).

(17) Failure to complete assignment of adjustment of a claim in a thorough and timely manner, including submission of the adjustment of a claim to the party which made that assignment.

B. If the commissioner of insurance denies an application or refuses to renew a license, he shall notify the applicant or licensee, in writing, in accordance and compliance with R.S. 49:961, of the reason for the denial or nonrenewal. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

C. The claims adjuster license of a business entity may be suspended, revoked, or refused if the commissioner of insurance finds, in accordance and compliance with R.S. 49:961, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers of the business entity and the violation was not reported to the commissioner of insurance.

D. In addition to denial, suspension, or revocation, a licensee may be fined for violating the provisions of this Section.

E. The commissioner of insurance shall have the authority to enforce the provisions of this Part and this Title against any person who is under investigation for or charged with a violation of this Part or this Title even if the person's license or registration has been surrendered or has lapsed by operation of law.

Renumbered from R.S. 22:1210.82 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2009, No. 317, § 1.

§ 1673. Continuing education

A. An individual who holds an adjuster license and who is not exempt under Subsection B of this Section shall satisfactorily complete a minimum of twenty-four hours of continuing education courses, including ethics, reported on a biennial basis in conjunction with the license renewal cycle.

B. This Section shall not apply to:

(1) Licensees not licensed for one full year prior to the end of the applicable continuing education biennium; or

(2) Licensees holding nonresident adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this state on the same basis.

C. Only continuing education courses approved by the commissioner of insurance shall be used to satisfy the continuing education requirement of Subsection A of this Section.

Renumbered from R.S. 22:1210.83 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1674. Standards of conduct

A. An adjuster shall not permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required under this Part.

B. An adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, or other consideration established with the insurer.

C. An adjuster shall not acquire any interest in salvage of property subject to the contract with the insurer.

D. An adjuster shall not solicit employment for, recommend or otherwise solicit engagement, directly or indirectly, for or on behalf of any attorney at law, contractor or subcontractor, in connection with any loss or damage with respect to which such adjuster is concerned or employed.

E. An adjuster shall not solicit or accept any compensation, direct or indirect, from, by, or on behalf of any contractor or subcontractor engaged by or on behalf of any insured by which such adjuster has been, is, or will be employed or compensated, directly or indirectly.

F. Adjusters shall also adhere to the following general requirements:

(1) An adjuster shall not undertake the adjustment of any claim if the adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise;

(2) An adjuster shall not knowingly make any oral or written material misrepresentations or statements which are false or maliciously critical and intended to injure any person engaged in the business of insurance;

(3) No adjuster, while so licensed by the department, may represent or act as a public adjuster; and

(4) No adjuster shall materially misrepresent to an insured or other interested party the terms and coverage of an insurance contract with intent and for the purpose of effecting settlement of a claim for loss or damage or benefit under such contract on less favorable terms than those provided in and contemplated by the insurance contract.

Renumbered from R.S. 22:1210.84 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1675. 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.

Renumbered from R.S. 22:1453 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1983, No. 474, § 1.

§ 1676. Referral by insurer

A. An insurer may not knowingly refer a claim or loss for adjustment to a person purporting to be or acting as an adjuster in this state unless the person holds a license under this Part.

B. Before referring a claim or loss for adjustment, an insurer must ascertain from the commissioner of insurance whether the person performing the adjustment holds a license under this Part. Once the insurer has ascertained that the person holds a license, the insurer may refer the claim or loss to the person and may continue to refer claims or losses to the person until the insurer has knowledge or receives information from the commissioner of insurance that the person no longer holds a license.

Renumbered from R.S. 22:1210.85 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1677. Reporting of actions

A. The adjuster shall report to the commissioner of insurance any administrative action taken against the adjuster in any jurisdiction or by another governmental agency within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent order, or other relevant legal documents.

B. Within thirty days of a conviction, the adjuster shall report to the commissioner of insurance any criminal prosecution of the adjuster taken in any jurisdiction for violation of insurance laws or regulations, any felony, or any misdemeanor involving misappropriation of funds. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

Renumbered from R.S. 22:1210.86 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

§ 1678. Regulations

The commissioner of insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the purposes of this Part.

Renumbered from R.S. 22:1210.87 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 783, § 1, eff. Jan. 1, 2007.

PART V. PUBLIC ADJUSTERS

§ 1691. Purpose

This Part governs the qualifications and procedures for the licensing of public

adjusters. It specifies the duties of and restrictions on public adjusters, which include limiting their licensure to assisting insureds in first-party claims in a manner which avoids the unauthorized practice of law as defined in R.S. 37:212 and 213.

Renumbered from R.S. 22:1210.91 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1692. Definitions

As used in this Part, unless the context requires otherwise, the following definitions shall be applicable:

(1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(2) "Fingerprints" means an impression of the lines on the finger taken for purpose of identification. The impression may be electronic or in ink converted to electronic format.

(3) "First-party claim" means a claim made by an insured or a policyholder under an insurance policy or contract that arises out of the occurrence of the contingency or loss covered by the policy or contract.

(4) "Home state" means the District of Columbia or any state or territory of the United States in which the public adjuster's principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which he becomes licensed and acts as a public adjuster to be the "home state".

(5) "Individual" means a natural person.

(6) "Person" means an individual or a business entity.

(7) "Public adjuster" means any person who, for any compensation, direct or indirect, engages in public adjusting.

(8) "Public adjusting" means either of the following:

(a) Investigating, appraising, or evaluating and reporting to an insured in relation to a first-party claim for which coverage is provided by an insurance contract that insures the property of the insured. Public adjusting does not include acting in any manner in relation to claims for damages to or arising out of the operation of a motor vehicle. Public adjusting does not include any activities which may constitute the unauthorized practice of law. Nothing in this Part shall be considered as permitting the unauthorized practice of law.

(b) Advertising for employment as a public adjuster of insurance claims or soliciting business or representing himself to the public as a public adjuster of first-party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property.

(9) "Uniform individual application" means the current version of the National Association of Insurance Commissioners (NAIC) uniform application for individual insurance license for resident and nonresident individuals.

(10) "Uniform business entity application" means the current version of the NAIC uniform application for business entity license for resident and nonresident business entities.

Renumbered from R.S. 22:1210.92 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1693. License required

A. A person shall not act or hold himself out as a public adjuster in this state unless the person is licensed as a public adjuster in accordance with this Part.

B. A person licensed as a public adjuster shall not misrepresent to a claimant that he is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster.

C. Only persons licensed under this Part shall directly or indirectly solicit business, investigate or adjust losses for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

D. A business entity acting as a public adjuster is required to obtain a public adjuster license. Application shall be made using the uniform business entity application. Before approving the application, the commissioner of insurance shall find that:

(1) The business entity has paid the fees set forth in R.S. 22:821.

(2) The business entity has designated a licensed public adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

E. Notwithstanding Subsections A through D of this Section, a license as a public adjuster shall not be required of any of the following:

(1) An attorney at law admitted to practice and in good standing in this state.

(2) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, or licensed attorney, including photographers, estimators, private investigators, engineers, and handwriting experts.

Renumbered from R.S. 22:1210.93 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1694. Application for license

A. A person applying for a public adjuster license shall make application to the commissioner of insurance on the appropriate uniform application or other

application required by the commissioner of insurance.

B. The applicant shall declare under penalty of perjury and 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 applicant's knowledge and belief.

C. (1) In order to make a determination of license eligibility, the commissioner of insurance is authorized to require fingerprints of applicants and submit the fingerprints and the fee required to perform the criminal history record checks to the Louisiana Bureau of Criminal Identification and Information and the Federal Bureau of Investigation (FBI) for state and national criminal history record checks. The commissioner of insurance shall require a criminal history record check on each applicant in accordance with this Part. The commissioner of insurance shall require each applicant to submit a full set of fingerprints in order for the commissioner of insurance to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(2) The commissioner of insurance may contract for the collection, transmission, and resubmission of fingerprints required under this Section. If the commissioner of insurance does so, the fee for collecting, transmitting, and retaining fingerprints shall be payable directly to the contractor by the person. The commissioner of insurance may agree to a reasonable fingerprinting fee to be charged by the contractor.

(3) The commissioner of insurance may waive submission of fingerprints by any person that has previously furnished fingerprints and those fingerprints are on file with the Central Repository of the NAIC, its affiliates, or subsidiaries.

(4) The commissioner of insurance is authorized to receive criminal history record information in lieu of the Louisiana Bureau of Criminal Identification and Information that submitted the fingerprints to the FBI.

(5) The commissioner of insurance is authorized to submit electronic fingerprint records and necessary identifying information to the NAIC, its affiliates, or subsidiaries for permanent retention in a centralized repository. The purpose of such a centralized repository is to provide insurance commissioners with access to fingerprint records in order to perform criminal history record checks.

Renumbered from R.S. 22:1210.94 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1695. Resident license

A. Before issuing a public adjuster license to an applicant under this Section, the commissioner of insurance shall find that the applicant:

(1) Is eligible to designate this state as his home state or is a nonresident who is not eligible for a license under R.S. 22:1698.

(2) Has not committed any act that is a ground for denial, suspension, or revocation of a license as set forth in R.S. 22:1700.

(3) Is financially responsible to exercise the license and has provided proof of financial responsibility as required in R.S. 22:1701.

(4) Has paid the fees set forth in R.S. 22:821.

(5) 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. In addition to satisfying the requirements of Subsection A of this Section, an individual shall:

(1) Be at least eighteen years of age.

(2) Have successfully passed the public adjuster examination.

(3) Not have been convicted of a crime involving fraud, coercive, or dishonest practices or demonstrating untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere.

C. In addition to satisfying the requirements of Subsection A of this Section, a business entity shall:

(1) Designate a licensed individual public adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

(2) Designate only licensed individual public adjusters to exercise the business entity's license.

D. The commissioner of insurance may require any documents reasonably necessary to verify the information contained in the application.

Renumbered from R.S. 22:1210.95 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1696. Examination

A. An individual applying for a public adjuster license pursuant to this Part shall pass a written examination unless exempt pursuant to R.S. 22:1697, 1698, or 1699. The examination shall test the knowledge of the individual concerning the duties and responsibilities of a public adjuster and the insurance laws and regulations of this state. Examinations required by this Section shall be developed and conducted pursuant to rules and regulations prescribed by the commissioner of insurance.

B. The commissioner of insurance may make arrangements, including contracting with an outside testing service in accordance with R.S. 39:1551, for administering examinations and collecting the nonrefundable fees set forth in R.S. 22:821.

C. Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the commissioner of insurance as set forth in R.S. 22:821.

D. An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

Renumbered from R.S. 22:1210.96 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1697. Exemptions from examination

A. An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in another state based on a public adjuster examination shall not be required to complete any examination. This exemption is available only if the person is currently licensed in that state or if the application is received within twelve months 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 or records maintained by the NAIC, its affiliates, or subsidiaries, indicate that the public adjuster is or was licensed in good standing.

B. An individual licensed as a public adjuster in another state based on a public adjuster examination who moves to this state shall make application within ninety days of establishing legal residence to become a resident licensee pursuant to R.S. 22:1695. No examination shall be required of that person to obtain a public adjuster license.

C. An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in this state shall not be required to complete any examination. This exemption is available only if the application is received within twelve months of the cancellation of the applicant's previous license in this state and if, at the time of cancellation, the applicant was in good standing in this state.

Renumbered from R.S. 22:1210.97 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1698. Nonresident license reciprocity

A. Unless denied licensure pursuant to R.S. 22:1700, a nonresident person may receive a nonresident public adjuster license if:

(1) The person is currently licensed as a resident public adjuster, and if an individual has passed a public adjuster examination which the commissioner of insurance has determined is no less stringent than the examination required by this Part, and is in good standing in his home state or, if his home state does not require examinations, he has passed the examination provided for in R.S. 22:1696.

(2) The person has paid the fees required by R.S. 22:821 and has provided proof of financial responsibility as required in R.S. 22:1701.

(3) The person has submitted or transmitted to the commissioner of insurance the

appropriate completed application for licensure.

(4) The person's home state awards nonresident public adjuster licenses to residents of this state on the same basis.

(5) The person has not been convicted of a crime involving fraudulent, coercive, or dishonest practices; or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere.

B. The commissioner of insurance may verify the public adjuster's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

C. (1) The commissioner of insurance shall not issue a license to any nonresident applicant until such applicant has filed forms approved by the commissioner of insurance which designate the commissioner of insurance 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 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.

(2) 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 as may be authorized by R.S. 22:821.

(3) 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 of insurance 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 of insurance 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.

D. As a condition to continuation of a public adjuster license issued pursuant to this Section, the licensee shall maintain a resident public adjuster license in his home state. The nonresident public adjuster license issued pursuant to this Section shall terminate and be surrendered immediately to the commissioner of insurance if the home state public adjuster license terminates for any reason, unless the public adjuster has been issued a license as a resident public adjuster in his new home state and the new home state awards nonresident public adjuster licenses to residents of this state on the same basis. Notification to the state or states where the nonresident license is issued shall be made as soon as possible, yet no later than thirty days of change in the new state resident license. The licensee shall include his current and prior address.

Renumbered from R.S. 22:1210.98 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1699. License

A. (1) Unless denied licensure under this Part, persons who have met the requirements of this Part may be issued a public adjuster license.

(2) A public adjuster license shall remain in effect unless revoked, terminated, or suspended, or denied renewal or reinstatement, as long as the request for renewal and fee set forth in R.S. 22:821 is paid and any other requirements for license renewal are met by the due date.

(3) Every licensed public adjuster shall file an application for renewal of his license every two years by notifying the commissioner of insurance, by methods required by the commissioner of insurance, of the licensee's intention to continue his license.

B. The licensee shall inform the commissioner of insurance by any means acceptable to the commissioner of insurance of a change of address, change of legal name, or change of information submitted on the application within thirty days of the change. Failure to file a change within the required time shall result in the imposition of a fifty dollar penalty per violation. 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 in accordance and compliance with Chapter 12 of this Title, R.S. 22:2191 et seq.

C. A public adjuster shall be subject to R.S. 22:1961 et seq. relative to unfair trade practices and R.S. 22:1921 et seq. relative to insurance fraud.

D. A public adjuster who allows his license to lapse may, within twelve months from the expiration date of the renewal, reinstate the license upon the commissioner of insurance's approval of the request for reinstatement. However, a penalty in the amount of double the unpaid renewal fee shall be required for the reinstatement of the public adjuster license. The public adjuster reinstatement shall be effective the date the commissioner of insurance approves the request for reinstatement and the late payment penalty is paid.

E. A licensed public adjuster that is unable to comply with license renewal procedures due to military service, a long-term medical disability, or some other extenuating circumstance may request a waiver of those procedures. The public adjuster may also request a waiver of any examination requirement, fine, or other sanction imposed for failure to comply with renewal procedures.

F. The license shall contain the licensee's name, city, and state of business address, license number, the date of issuance, the expiration date, and any other information the commissioner of insurance deems necessary.

G. In order to assist in the performance of the commissioner of insurance's duties, the commissioner of insurance may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees and data, related to licensing that the commissioner of insurance may deem appropriate.

Renumbered from R.S. 22:1210.99 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2009, No. 317, § 1; Acts

2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1700. License denial, nonrenewal, or revocation

A. The commissioner of insurance may place on probation, suspend, revoke, or refuse to issue, renew, or reinstate a public adjuster's license and 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, unless a fine is established by separate statute in this Title authorizing a greater penalty, or any combination of actions, for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in the license application.

(2) Violating any insurance laws, or violating any regulation, subpoena, or order of the commissioner of insurance or of another state's insurance commissioner.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business.

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(6) Having been convicted of a felony.

(7) Having admitted or been found to have committed any insurance unfair trade practice or insurance fraud.

(8) Having an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory.

(9) Forging another's name to an application for insurance or to any document related to an insurance transaction.

(10) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license.

(11) Knowingly accepting insurance business from an individual who is not licensed but who is required to be licensed by the commissioner of insurance.

(12) Failing to comply with an administrative or court order imposing a child support obligation.

(13) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax.

(14) Violating R.S. 22:1706(H).

B. The commissioner of insurance shall place on probation, suspend, revoke, or refuse to issue, renew, or reinstate a public adjuster's license and shall 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, unless a fine is established by separate statute in this Title authorizing a greater penalty, or any combination of actions, for the following:

(1) Having been convicted of a serious crime involving fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere.

(2) Engaging in the unauthorized practice of law as defined in R.S. 37:212 and 213.

C. In the event that the action by the commissioner of insurance is to deny an application for or not renew a license, the commissioner of insurance shall notify the applicant or licensee and advise, in writing, in accordance and compliance with R.S. 49:961, the applicant or licensee of the reason for the nonrenewal or denial of the applicant's or licensee's license. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

D. The license of a business entity may be suspended, revoked, or refused if the commissioner of insurance finds, after complying with R.S. 49:961, 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 neither reported to the commissioner of insurance nor corrective action taken.

E. In addition to or in lieu of any applicable denial, suspension, or revocation of a license, a person may, after hearing, be subject to a fine as provided herein after the commissioner's compliance with R.S. 49:961.

F. The commissioner of insurance shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this Part and this Title against any person who is under investigation for or charged with a violation of this Part or this Title even if the person's license or registration has been surrendered or has lapsed by operation of law.

Renumbered from R.S. 22:1210.100 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2009, No. 317, § 1.

§ 1701. Evidence of financial responsibility

A. Prior to issuance of a license as a public adjuster and for the duration of the license, the applicant shall secure evidence of financial responsibility in a format prescribed by the commissioner of insurance through a security bond or irrevocable letter of credit:

(1) A surety bond executed and issued by an insurer authorized to issue surety bonds in this state, which bond:

(a) Shall be in the minimum amount of fifty thousand dollars.

(b) Shall be in favor of this state and shall specifically authorize recovery by the commissioner of insurance on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or

conviction of unfair practices in his capacity as a public adjuster; and

(c) Shall not be terminated unless at least thirty days' prior written notice will have been filed with the commissioner of insurance and given to the licensee.

(2) An irrevocable letter of credit issued by a qualified financial institution authorized to do and doing business in this state, which letter of credit:

(a) Shall be in the minimum of fifty thousand dollars;

(b) Shall be to an account to the commissioner of insurance and subject to lawful levy of execution on behalf of any person to whom the public adjuster has been found to be legally liable as the result of erroneous acts, failure to act, fraudulent acts, or unfair practices in his capacity as a public adjuster.

(c) Shall not be terminated unless at least thirty days' prior written notice will have been filed with the commissioner of insurance and given to the licensee.

B. The issuer of the evidence of financial responsibility shall notify the commissioner of insurance upon termination of the bond or letter of credit, unless otherwise directed by the commissioner of insurance.

C. The commissioner of insurance may ask for the evidence of financial responsibility at any time he deems relevant.

D. The authority to act as a public adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

Renumbered from R.S. 22:1210.101 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1702. Continuing education

A. An individual who holds a public adjuster license and who is not exempt under Subsection B of this Section shall satisfactorily complete a minimum of twenty-four hours of continuing education courses, including ethics, reported on a biennial basis in conjunction with the license renewal cycle.

B. This Section shall not apply to:

(1) Licensees not licensed for one full year prior to the end of the applicable continuing education biennium.

(2) Licensees holding nonresident public adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this state on the same basis.

C. Only continuing education courses approved by the commissioner of insurance shall be used to satisfy the continuing education requirement of Subsection A of this Section.

Renumbered from R.S. 22:1210.102 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1703. Public adjuster fees

A. A public adjuster may charge the insured a reasonable fee. A public adjuster shall not solicit for or enter into 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, or calculated as a percentage of, the amount of any claim or claims paid to or on behalf of an insured by the insurer and any such contract shall be against public policy and is null and void.

B. A public adjuster shall not pay a commission, service fee, or other valuable consideration to another for public adjusting in this state if that person is required to be licensed under this Part and is not so licensed.

C. A person shall not accept a commission, service fee, or other valuable consideration for public adjusting in this state if that person is required to be licensed under this Part and is not so licensed.

Renumbered from R.S. 22:1210.103 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1704. Contract between public adjuster and insured

A. Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

(1) Legible full name of the adjuster signing the contract, as specified in Department of Insurance records.

(2) Permanent home state business address and phone number.

(3) Department of Insurance license number.

(4) Title of "Public Adjuster Contract".

(5) The insured's full name, street address, insurance company name, and policy number, if known or upon notification.

(6) A description of the loss and its location, if applicable.

(7) Description of services to be provided to the insured.

(8) Signatures of the public adjuster and the insured.

(9) Date contract was signed by the public adjuster and date that the contract was signed by the insured.

(10) Attestation language stating that the public adjuster has satisfied the financial responsibility requirements of state law.

(11) Full salary, fee, compensation, or other considerations the public adjuster is to receive for services.

(12) If applicable, an acknowledgment that a mortgage holder exists on any property adjusted by the public adjuster and that such mortgage holder is or may

be an additional insured on the claim.

B. Compensation provisions in a public adjusting contract shall not be redacted in any copy of the contract provided to the commissioner of insurance. Such a redaction shall constitute an omission of material fact.

C. If the insurer, not later than seventy-two hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

(1) Inform the insured that the loss recovery amount cannot be increased by the insurer.

(2) Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

D. A public adjuster contract may not contain any contract term that:

(1) Allows the public adjuster's fee to be collected when money is due from an insurance company, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company.

(2)(a) When any payment on a claim is made and the insured is represented by a public adjuster, the insurer's check or checks may be made payable to the insured and the public adjuster when all of the following occurs:

(i) The amount of the check does not exceed the public adjuster's fee.

(ii) The amount of the fee is indicated in a written compensation agreement signed by the insured.

(iii) The balance of the proceeds, not included in the check made payable to the insured and the public adjuster, is made payable to the insured or to the insured and other lienholder or holders as is required by law.

(b) Should a dispute arise between a public adjuster and the insured with which he contracts, the public adjuster is prohibited from acting in any manner which would interfere with or cause the insured not to receive the undisputed portion of the insurance proceeds. Should the insured's check, which contains that amount not associated with the public adjuster's fee, be mailed to or received by the public adjuster, the public adjuster shall promptly present the check to the insured.

(3) Imposes collection costs or late fees.

(4) Precludes the insured from pursuing civil or judicial remedies.

E. Prior to the signing of the contract, the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states:

(1) Property insurance policies obligate the insured to present a claim to his insurance company for consideration. There are three types of adjusters that could be involved in that process. The definitions of the three types are as follows:

(a) "Company adjusters" means the insurance adjusters who are employees of an insurance company. They represent the interest of the insurance company and are paid by the insurance company. Company adjusters shall not charge insureds a fee.

(b) "Independent adjusters" means the insurance adjusters who are hired on a contract basis by an insurance company to represent the insurance company's interest. They are paid by your insurance company. Independent adjusters shall not charge insureds a fee.

(c) "Public adjusters" means the insurance adjusters who do not work for any insurance company. They work for the insured to assist in the investigation, appraisal, evaluation, and reporting of the claim. The insured hires them by signing a contract agreeing to pay them a fee.

(2) The insured is not required to hire a public adjuster to help the insured meet his obligations under the policy but has the right to do so.

(3) The insured always has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, and the insurer's attorney, or any other person regarding the settlement of the insured's claim. Once a public adjuster has been retained, the public adjuster shall not restrict communications between the insurer and its insured.

(4) The public adjuster is not a representative or employee of the insurer.

(5) The salary, fee, or other consideration to be paid to the public adjuster is the obligation of the insured, not the insurer.

F. The contracts shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the commissioner of insurance.

G. The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, indicating that the insured and the public adjuster have a contract pursuant to this Part. Delivery of this letter shall not prohibit or impede the right of the insured to communicate directly with the insurer.

H. The insured has the right to rescind the contract within three business days after the date the contract was signed. The rescission shall be in writing and mailed or delivered to the public adjuster at the address in the contract within the three business day period.

I. If the insured exercises the right to rescind the contract, any thing of value given by the insured under the contract will be returned to the insured within fifteen business days following the receipt by the public adjuster of the cancellation notice.

J. The contract shall not be construed to prevent an insured from pursuing any civil or judicial remedy.

Renumbered from R.S. 22:1210.104 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1705. Record retention

A. A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this Section shall include the following:

(1) Name of the insured.

(2) Date, location, and amount of the loss.

(3) Copy of the contract between the public adjuster and insured.

(4) Name of the insurer, amount, expiration date, and number of each policy carried with respect to the loss.

(5) Itemized statement of the insured's recoveries.

(6) Itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss.

(7) A register of all monies received, deposited, disbursed, or withdrawn in connection with a transaction with an insured.

(8) Name of the public adjuster who executed the contract.

(9) Name of the attorney representing the insured, if applicable, and the name of the claims representative of the insurance company.

(10) Evidence of financial responsibility in a format prescribed by the commissioner of insurance.

B. Records shall be maintained for at least five years after the termination of the transaction with an insured and shall be open to examination by the commissioner of insurance at all times.

Renumbered from R.S. 22:1210.105 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1706. Standards of conduct of public adjuster

A. A public adjuster is obligated, under his license, to serve with objectivity and complete loyalty to the interest of his insured alone and to render to the insured such information and service, as within the knowledge, understanding, and good faith of the licensee, as will best serve the insured's insurance claim needs and interest.

B. A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

C. A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this Part.

D. A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the compensation established in the written contract with the insured.

E. A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured.

F. A public adjuster shall not solicit employment for or otherwise solicit engagement, directly or indirectly, for or on behalf of any attorney at law, contractor, or subcontractor, in connection with any loss or damage with respect to which such adjuster is concerned or employed. Nothing in this Part shall be interpreted to prevent a public adjuster from recommending a particular attorney, contractor or subcontractor; however, the public adjuster is prohibited from collecting any fee, compensation, or thing of value for such referral.

G. A public adjuster shall not solicit or accept any compensation, direct or indirect, from, by, or on behalf of any contractor or subcontractor engaged by or on behalf of any insured by which such adjuster has been, is, or will be employed or compensated, directly or indirectly.

H. Public adjusters shall also adhere to the following general requirements:

(1) No public adjuster, while so licensed by the department, may represent or act as a company adjuster or independent adjuster in Louisiana.

(2) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the authority to choose the persons who shall perform repair work.

(3) A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

(4) A public adjuster shall not file or record on behalf of an insured client any complaint to or with any court of record or agency of the state.

(5) A public adjuster shall not provide services with any claim except a first-party claim on behalf of an insured against such insured's insurer.

(6) A public adjuster shall not provide services to the insured in connection with any claim for personal injury.

(7) A public adjuster shall not render legal advice to the insured, including but not limited to legal advice regarding the policy provisions or coverage issues.

(8) A public adjuster shall not engage in the unauthorized practice of law as

defined in R.S. 37:212 and 213.

(9) A public adjuster may not agree to any loss settlement without the insured's knowledge and written consent.

(10) A public adjuster shall not act as an appraiser or umpire pursuant to the appraisal provisions of R.S. 22:1311 or any similar provision of a policy of insurance if that public adjuster is adjusting or has adjusted all or any part of the claim, or both, or property subject to that appraisal provision.

Renumbered from R.S. 22:1210.106 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012; Acts 2012, No. 309, § 1.

§ 1707. Reporting of actions

A. The public adjuster shall report to the commissioner of insurance any administrative action taken against the public adjuster in any jurisdiction or by another governmental agency within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent order, or other relevant legal documents.

B. Within thirty days of a conviction, the public adjuster shall report to the commissioner of insurance any criminal prosecution of the public adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

Renumbered from R.S. 22:1210.107 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

§ 1708. Regulations

The commissioner of insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the purposes of this Part.

Renumbered from R.S. 22:1210.108 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 806, § 1.

PART VI. REINSURANCE INTERMEDIARY

§ 1721. Title

This Part may be cited as the "Reinsurance Intermediary Law".

Renumbered from R.S. 22:1210.20 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

§ 1722. 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) "Business entity" shall mean a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(3) "Controlling person" shall mean any person who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

(4) "Individual" shall mean a natural person.

(5) "Insurer" shall mean any authorized insurer as defined in R.S. 22:46.

(6) "Licensed producer" shall mean a person licensed as an insurance producer pursuant to the provisions of Subpart A of Part I of this Chapter, R.S. 22:1541 et seq., or a person licensed as a reinsurance intermediary-broker licensed pursuant to this Part.

(7) "Person" shall mean an individual or business entity.

(8) "Reinsurance intermediary" shall mean a reinsurance intermediary-broker or a reinsurance intermediary-manager.

(9) "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.

(10) "Reinsurance intermediary-manager" shall mean any person 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 any previous provision of this Section, 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, R.S. 22:691 et seq., 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.

(11) "Reinsurer" shall mean any person duly licensed in this state, pursuant to the applicable provisions of this Code, as an insurer with the authority to assume reinsurance.

(12) "Qualified United States financial institution" 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.

(13) "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.

Renumbered from R.S. 22:1210.21 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1723. Licensure

A. No person shall act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office either directly or as a member, officer, director, or employee of a business entity:

(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 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, officer, director, or employee of a business entity 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 who has complied with the requirements of this Part. Any such license issued to a business entity will authorize all the members, officers, and designated employers and directors of the business entity to act as reinsurance intermediaries under the license, 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, to whom notices or orders or process affecting such nonresident reinsurance intermediary may be served.

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 Part.

Renumbered from R.S. 22:1210.22 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1724. Required contract provisions for reinsurance intermediary-brokers

Any transactions between a reinsurance intermediary-broker and the insurer the broker represents in such capacity shall be entered into only 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. 22:1725.

(5) The reinsurance intermediary-broker shall 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.

Renumbered from R.S. 22:1210.23 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1725. 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.

Renumbered from R.S. 22:1210.24 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

§ 1726. Duties of insurers utilizing the services of a reinsurance intermediary-broker

A. An insurer shall not engage the services of any person to act as a reinsurance intermediary-broker on its behalf, unless such person is licensed as required by R.S. 22:1723(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, R.S. 22:691 et seq.

C. The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

Renumbered from R.S. 22:1210.25 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1727. Required contract provisions for reinsurance intermediary-managers

A. Any transactions between a reinsurance intermediary-manager and the reinsurer represented in its capacity shall be entered into only 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 while any dispute regarding the cause for termination is pending.

(2) The reinsurance intermediary-manager shall 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 shall 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 shall 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. 22:1729(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 shall comply with the written

underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The contract 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 while any dispute regarding the cause of termination is pending.

C. If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, that such interim profits shall 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. 22:1729(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 shall 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.

Renumbered from R.S. 22:1210.26 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1728. 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, R.S. 22:691 et seq.

(7) Appoint a subreinsurance intermediary-manager.

Renumbered from R.S. 22:1210.27 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1729. Duties of reinsurers utilizing the services of a reinsurance intermediary-manager

A. A reinsurer shall not engage the services of any person to act as a reinsurance intermediary-manager on its behalf unless such person is licensed as required by R.S. 22:1723(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, R.S. 22:691 et seq. or, if applicable, the Business Transacted with Producer Controlled Insurer Law, R.S. 22:551 et seq.

Renumbered from R.S. 22:1210.28 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1730. 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.

Renumbered from R.S. 22:1210.29 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

§ 1731. Penalties and liabilities

A. Any reinsurance intermediary, insurer, or reinsurer found by the commissioner,

after a public hearing, 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 or certificate of authority.

(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.

Renumbered from R.S. 22:1210.30 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1. Amended by Acts 2009, No. 317, § 1; Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1732. Rules and regulations

The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this Part.

Renumbered from R.S. 22:1210.31 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 811, § 1.

PART VII. PROFESSIONAL EMPLOYER ORGANIZATIONS

§ 1741. Purpose

The purpose of this Part is to provide for professional employment services by defining such services, requiring registration of persons providing such services, providing for employee benefits plans and workers' compensation coverage for participants of such services, and providing for enforcement of this Part.

Renumbered from R.S. 22:1210.51 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1742. 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 commissioner of insurance, as provided for in R.S. 22:1451 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.

Renumbered from R.S. 22:1210.52 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1743. 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.

Renumbered from R.S. 22:1210.53 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1744. 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.

Renumbered from R.S. 22:1210.54 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1745. 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.

Renumbered from R.S. 22:1210.55 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1746. 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 commissioner of insurance as provided in R.S. 22:1451, 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. Repealed by Acts 2011, No. 94, § 2, eff. Jan. 1, 2012.

Renumbered from R.S. 22:1210.56 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, §§ 1, 3, eff. Jan. 1, 2002.

§ 1747. 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 or insurance producer; 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 producer in accordance with this Title.

Renumbered from R.S. 22:1210.57 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1748. 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.

Renumbered from R.S. 22:1210.58 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1749. Enforcement

The provisions of this Part may be enforced by the commissioner pursuant to R.S. 22:1967 through 1970 and other applicable provisions of this Title.

Renumbered from R.S. 22:1210.59 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1750. Implementation

The department may promulgate such rules and regulations, pursuant to the Administrative Procedure Act, as are necessary to implement this Part.

Renumbered from R.S. 22:1210.60 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1150, § 1.

§ 1751. Electronic registration; registration through an approved assurance organization

A. The commissioner is authorized, to the extent practical, to accept the electronic filing of a PEO registration that is in conformance with the Louisiana Uniform Electronic Transactions Act, R.S. 9:2601 et seq., including applications, documents, reports, and other filings required by this Part.

B. The commissioner is further authorized, to the extent practical, to provide for the acceptance of electronic filings and other assurance documents by an independent and qualified assurance organization approved by the commissioner that provides satisfactory assurance of compliance with the applicable provisions

of this Part. The commissioner may permit a PEO to authorize such an approved assurance organization to act on the PEO's behalf in complying with the registration requirements of this Part, including the electronic filing of applications, documents, reports, registration fees, and other information. Use of such an approved assurance organization shall be optional and not mandatory for any PEO.

C. Nothing in this Section shall limit or change the authority of the commissioner to register or terminate the registration of a PEO or to investigate or enforce any provision of this Part.

Added by Acts 2012, No. 387, § 1.

PART VIII. MOTOR VEHICLE RENTAL INSURERS

§ 1761. 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 of selling travel or automobile-related products or coverage in connection with and incidental to the rental of vehicles.

Renumbered from R.S. 22:2101 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1762. 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.

Renumbered from R.S. 22:2102 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999.

§ 1763. 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 pursuant to this Part, there shall be filed with the commissioner a written application for a limited license, 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. The application shall be accompanied by such fee as provided by R.S. 22:821. 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 as provided by R.S. 22:821.

Renumbered from R.S. 22:2103 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1764. 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.

Renumbered from R.S. 22:2104 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999.

§ 1765. 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.

Renumbered from R.S. 22:2105 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999.

§ 1766. 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.

C. 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 provided to the commissioner within two weeks of written demand from the commissioner.

Renumbered from R.S. 22:2106 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1767. 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 if 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.

Renumbered from R.S. 22:2107 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1768. Representations

No limited licensee pursuant to this Part shall advertise, represent, or otherwise hold itself or any of its employees or agents out as licensed insurers or insurance producers.

Renumbered from R.S. 22:2108 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999. Amended by Acts 2011, No. 94, § 1, eff. Jan. 1, 2012.

§ 1769. Repealed by Acts 2011, No. 94, § 2, eff. Jan. 1, 2012

§ 1770. 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.

Renumbered from R.S. 22:2110 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999.

§ 1771. 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.

Renumbered from R.S. 22:2111 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999.

§ 1772. 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.

Renumbered from R.S. 22:2112 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1278, § 1, eff. July 12, 1999.

PART VIII-A. PORTABLE ELECTRONICS INSURANCE

§ 1781.1. Definitions

As used in this Part, the following terms shall have the following meanings:

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

(2) "Customer" means a person who purchases portable electronics or services.

(3) "Department" means the Department of Insurance.

(4) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(5) "Location" means any physical location in the state of Louisiana or any website, call center site, or similar location directed to residents of the state of Louisiana.

(6) "Portable electronics" means electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(7)(a) "Portable electronics insurance" means insurance providing coverage for the repairs or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss.

(b) "Portable electronics insurance" does not include any of the following:

(i) A service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property for the operational or structural failure of such property due to a defect in materials, workmanship, accidental damage from handling, power surges, or normal wear and tear.

(ii) A policy of insurance covering a seller's or a manufacturer's obligations under a warranty.

(iii) A homeowner's, renter's, private passenger automobile, commercial

multi-peril, or similar policy.

(8) "Portable electronics transaction" means any of the following:

(a) The sale or lease of portable electronics by a vendor to a customer.

(b) The sale of a service related to the use of portable electronics by a vendor to a customer.

(9) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

Added by Acts 2012, No. 311, § 1.

§ 1781.2. Licensure of vendors

Notwithstanding any other provision of law to the contrary, the following requirements apply to the licensure of vendors of portable electronic devices:

(1) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(2) A limited lines license issued pursuant to this Section shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions. The vendor shall be responsible for the conduct and actions related to the sale or offering of portable electronics insurance of all employees and authorized representatives and any payment of the premium for portable electronics insurance to an employee or authorized representative shall be deemed payment to the vendor.

(3) In connection with a vendor's application for licensure and upon license renewal, the vendor shall provide a list to the commissioner of all locations in the state at which it offers coverage.

Added by Acts 2012, No. 311, § 1.

§ 1781.3. Requirements for sale of portable electronics insurance

A. In conjunction with and at the time of the sale of every portable electronics insurance policy, the vendor shall present brochures or other written materials to a prospective customer which:

(1) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage.

(2) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services.

(3) Summarize the material terms of the insurance coverage, including:

(a) The identity of the insurer.

(b) The amount of any applicable deductible and how it is to be paid.

(c) The benefits of the coverage.

(d) The key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or non-original manufacturer parts or equipment.

(4) Contain a summary of the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirement.

(5) Contain a statement that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund or credit for any applicable unearned premium.

B. Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

Added by Acts 2012, No. 311, § 1.

§ 1781.4. Authority of vendors of portable electronics

A. An employee or authorized representative of a vendor may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Part provided that:

(1) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to this Part.

(2) The vendor shall develop a training program for employees and authorized representatives of the vendor. The training required by this Section shall comply with all of the following:

(a) The training shall be delivered to employees and authorized representatives of vendors who are directly engaged in the activity of selling or offering portable electronics insurance prior to the engagement in any sale or offer of portable electronics insurance to any customer by the employee or authorized representative.

(b) The training may be provided in electronic form.

(c) The training shall include instruction about the portable electronics insurance offered to customers and the disclosures required under this Part.

B. Notwithstanding any other provision of law to the contrary, employees or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited lines license which is incidental to their overall compensation.

C. The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within sixty days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

Added by Acts 2012, No. 311, § 1.

§ 1781.5. Suspension or revocation of license

If a vendor of portable electronics or its employee or authorized representative violates any provision of this Part or any other applicable provision of this Title, the commissioner may, after notice and opportunity for a hearing, take any one or more of the following actions:

(1) Impose fines not to exceed five hundred dollars per violation or five thousand dollars in the aggregate for such conduct.

(2) Suspend or revoke the limited lines license of the vendor.

(3) Suspend the privilege of transacting portable electronics insurance at specific business locations where violations have occurred.

(4) Suspend or revoke the ability of individual employees or authorized representatives to act under the license of the vendor.

Added by Acts 2012, No. 311, § 1.

§ 1781.6. Application for license and fees

A. An application for a license pursuant to this Part shall be made to and filed with the commissioner on forms prescribed and furnished by the commissioner and shall include the legal name of the applicant, the address of the home office of the applicant, the name and identifying information for all officers, all directors and all persons who own directly or indirectly ten percent or more of the applicant and such other information as the commissioner may reasonably require. However, any applicant whose stock is publicly traded and registered under the federal securities laws or that is licensed pursuant to the Federal Communications Act of 1934, or any affiliate or subsidiary thereof, may, in lieu of providing the name and identifying information for all officers, all directors and all persons who own directly or indirectly ten percent or more of the applicant, designate a single officer as the designated responsible person for the activities of the vendor pursuant to the limited lines portable electronics

insurance license. The name and identifying information only for such single designated responsible person is then required.

B. The application shall be accompanied by the fee pursuant to R.S. 22:821(B)(35).

C. Any vendor engaging in portable electronics insurance transactions on or before the effective date of this Part shall apply for licensure within ninety days of the application being made available by the commissioner.

D. Every license issued pursuant to this Part shall expire on December thirty-first of the renewal year assigned by the commissioner and may be renewed by the filing of a renewal application as required by the commissioner and payment of the fee required by R.S. 22:821(B)(35).

Added by Acts 2012, No. 311, § 1.

PART VIII-B. LIMITED LINES TRAVEL INSURANCE

§ 1782.1. Definitions

As used in this Part, the following terms shall have the following meanings:

(1) "Limited lines travel insurance producer" means any of the following:

(a) Licensed managing general underwriter.

(b) Licensed managing general agent or third party administrator.

(c) Licensed insurance producer, including a limited lines producer, designated by an insurer as the travel insurance supervising entity as set forth in R.S. 22:1782.2(C).

(2) "Offer and disseminate" means to provide general information, including a description of the coverage and price, as well as process the application, collect premiums, and perform other nonlicensable activities permitted by the state.

(3)(a) "Travel insurance", except as provided in Subparagraph (b) of this Paragraph, means insurance coverage for personal risks incident to planned travel, including but not limited to the following:

(i) Interruption or cancellation of a trip or event.

(ii) Loss of baggage or personal effects.

(iii) Damages to accommodations or rental vehicles.

(iv) Sickness, accident, disability, or death occurring during travel.

(b) "Travel insurance" shall not mean major medical plans, which provide comprehensive medical protection for travelers with trips lasting six months or longer, including those working overseas as expatriates, or military personnel being deployed.

(4) "Travel retailer" means a business entity that makes, arranges, or offers

travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

Added by Acts 2014, No. 117, § 1.

§ 1782.2. Requirements for sale of limited lines travel insurance

A. Notwithstanding any other provision of law to the contrary, the commissioner may issue to an individual or business entity that has filed with the commissioner an application for such limited license in a form and manner prescribed by the commissioner, a limited lines travel insurance producer license, which authorizes the limited lines travel insurance producer to sell, solicit, or negotiate travel insurance through a licensed insurer. The limited lines travel insurance producer shall pay all applicable insurance producer licensing fees as set forth in R.S. 22:821.

B. At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register, on a form prescribed by the commissioner, of each travel retailer that offers travel insurance on the limited lines producer's behalf. The register shall be maintained and updated annually by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the commissioner upon reasonable request. The limited lines producer shall also certify that the registered travel retailer is not in violation of 18 U.S.C. § 1033.

C. A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity ("licensed business entity") license only if the limited lines travel insurance producer or travel retailer provides written material to purchasers of travel insurance including each of the following:

(1) A description of the material terms or the actual material terms of the insurance coverage.

(2) A description of the process for filing a claim.

(3) A description of the review or cancellation process for the travel insurance policy.

(4) The identity and contact information of the insurer and limited lines producer.

(5) An explanation that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer.

(6) An explanation that an unlicensed employee or representative of a travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the

adequacy of the customer's existing insurance coverage.

D. The limited lines travel insurance producer shall designate one of its employees who is a licensed individual producer as the designated responsible producer for the limited lines travel insurance producer's compliance with the Louisiana travel insurance laws, rules, and regulations. The designated responsible producer, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines insurance producer. As the insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this Part. The limited lines travel insurance producer and any travel retailer offering and disseminating travel insurance under the limited lines travel insurance producer license shall be subject to the applicable unfair trade practice provisions pursuant to R.S. 22:1963 et seq.

E. The limited lines travel insurance producer shall require each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training which may be subject to review by the commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers. Limited lines travel insurance producers, and those registered under the producers' licenses are exempt from pre-licensing and continuing education requirements under R.S.22:1573.

F. A travel retailer's employee or authorized representative who is not licensed as an insurance producer shall not do any of the following:

(1) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage.

(2) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage.

(3) Hold himself or itself out as a licensed insurer, licensed producer, or insurance expert.

Added by Acts 2014, No. 117, § 1.

§ 1782.3. Compensation

Notwithstanding any other provision of law to the contrary, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this Part, is authorized to do so and receive related compensation for such services, upon registration by the limited lines travel insurance producer as set forth in R.S. 22:1782.2(B).

Added by Acts 2014, No. 117, § 1.

PART IX. VIATICAL SETTLEMENTS

§ 1791. 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, the viatical settlement provider, the viatical settlement broker, or the viator. "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;

(e) Facilitating, directly or indirectly, the change of state of ownership of a policy or the state of residency of a viator to avoid the provisions of this Part; or

(f) 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, in this state, from this state, or with a resident of this state, 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) A qualified institutional buyer as defined in 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.

Renumbered from R.S. 22:191 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1. Amended by Acts 2006, No. 499, § 1, eff. June 22, 2006.

§ 1792. 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 Subpart A of Part I of Chapter 5 of this Title 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. 22:821.

C. Licenses issued pursuant to this Part shall expire on March 1, 2008, and on March first of each year thereafter and may be renewed if the applicant pays a renewal fee as set forth in R.S. 22:821 and submits to the commissioner an application on the form that the commissioner requires. The required fee and renewal application shall be filed no earlier than January first and no later than March first of each year. A licensee under this Part choosing not to renew shall still be responsible for the annual statement required by R.S. 22:1795 for the previous calendar year.

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. 22:1801(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.

Renumbered from R.S. 22:191.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1. Amended by Acts 2006, No. 371, § 1, eff. June 15, 2006.

§ 1793. 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 utilizes any viatical settlement contract form, or any other form required to be approved, 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. The commissioner may suspend, revoke, or refuse to renew the license of a viatical settlement broker, including the viatical settlement broker's insurance producer license, if the commissioner finds that such viatical settlement broker:

(1) Has violated the provisions of this Part;

(2) Has received a fee, commission, or other valuable consideration for his services with respect to viatical settlement transactions that involved unlicensed viatical settlement providers or viatical settlement brokers; or

(3) Deals in bad faith with viators.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:192 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1. Amended by Acts 2006, No. 499, § 1, eff. June 22, 2006; Acts 2009, No. 317, § 1.

§ 1794. 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. 22:821.

Renumbered from R.S. 22:192.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1795. Reporting requirements and privacy

A. Each person acting as a viatical settlement broker, viatical settlement provider, or viatical settlement investment agent, including but not limited to licensed insurance producers acting as viatical settlement brokers pursuant to the authority granted by R.S. 22:1792(A)(1), 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. 22:1801(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.

Renumbered from R.S. 22:193 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1. Amended by Acts 2006, No. 369, § 1, eff. June 15, 2006.

§ 1796. 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 Chapter 12 of this Title, 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.

Renumbered from R.S. 22:193.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1797. 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.

Renumbered from R.S. 22:194 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1798. 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. 22:1797(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. 22:1797(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.

Renumbered from R.S. 22:194.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1799. Prohibited practices

A. It is a violation of this Part for any person to enter into a viatical settlement contract at any time prior to the application for or issuance of a life insurance policy or certificate which is the subject of a viatical settlement contract or for a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies and submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

(1) The viator or insured is terminally or chronically ill; or

(2) 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.

B. (1) Documents required by R.S. 22:1798(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.

(2) If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in Subsection A 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.

Renumbered from R.S. 22:195 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1. Amended by Acts 2006, No. 499, § 1, eff. June 22, 2006.

§ 1800. 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.

Renumbered from R.S. 22:196 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1801. 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, and where the policy is the subject of such suspected fraudulent viatical settlement act to the insurer that issued the policy, 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), the Financial Industry Regulatory Authority, 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.

(5) Paragraph (1) of this Subsection does not apply to a person's furnishing information concerning his or its own suspected, anticipated, or completed fraudulent viatical settlement acts or suspected, anticipated, or completed fraudulent insurance acts.

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.

Renumbered from R.S. 22:197 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1. Amended by Acts 2006, No. 499, § 1, eff. June 22, 2006; Acts 2010, No. 7, § 3, eff. May 19, 2010.

§ 1802. 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 Chapter 12 of this Title.

Renumbered from R.S. 22:198 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1803. Unfair trade practices

A violation of this Part shall be considered an unfair trade practice under Part IV of Chapter 7 of this Title subject to the penalties contained in that Part.

Renumbered from R.S. 22:199 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1804. 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.

Renumbered from R.S. 22:200 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 343, § 1.

§ 1805. Applicability

Nothing in this Part preempts or otherwise limits the provisions of R.S. 6:101 et seq. or R.S. 51:701 et seq. or any regulations, orders, policy statements, notices, bulletins, or other interpretations issued by or through the commissioner of financial institutions or his designee acting pursuant to R.S. 6:101 et seq. or R.S. 51:701 et seq. Compliance with the provisions of this Part does not constitute compliance with any applicable provision of R.S. 6:101 et seq. or R.S. 51:701 et seq. and any amendments thereto or any regulations, orders, policy statements, notices, bulletins, or other interpretations issued by or through the commissioner of financial institutions or his designee acting pursuant to the provisions of R.S. 6:101 et seq. or R.S. 51:701 et seq.

Renumbered from R.S. 22:200.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 499, § 1, eff. June 22, 2006.

PART X. HOME SERVICE CONTRACT PROVIDERS [REPEALED]

2015 Repeal and Enactment—Acts 2015, No. 161

Acts 2015, No. 161, § 1 enacts Chapter 57, "Home Service Contract Providers", of TItle 51 of the Louisiana Revised Statutes of 1950, comprised of R.S. 51:3141 to 51:3146. Section 2 of Acts 2015, No. 161 repeals Part X of Chapter 5 of Title 22, comprised of R.S. 22:1806.1 to 1806.9 and repeals par. (B)(30) of R.S. 22:821.

Section 3 of Act 161 provides:

"(A) This Section, all provisions enacted by Section 1 of this Act except R.S. 51:3143(A)(5) and (B), and the provisions of Section 2 of this Act, shall become effective on January 11, 2016.

"(B) The provisions of R.S. 51:3143(A)(5) and (B) as enacted by Section 1 of this Act shall become effective on January 15, 2016."

§ 1806.1 to 1806.9. Repealed by Acts 2015, No. 161, § 2, eff. Jan. 11, 2016

PART XI. REGISTRATION OF APPRAISERS FOR FIRE AND EXTENDED COVERAGE

§ 1807.1. Registration required

A. No person shall act as, or hold himself out to be, an appraiser in accordance with the provisions of R.S. 22:1311(F)(2) unless such person is registered with the commissioner of insurance as an appraiser.

B. Each person shall register with the commissioner on a form to be prescribed by the commissioner and shall pay the fee required by R.S. 22:821(B)(34).

C. Each registration submitted pursuant to this Part shall expire each year on the anniversary date and may be renewed by filing a request for renewal on a form to be prescribed by the commissioner and by paying the renewal fee required by R.S. 22:821(B)(34).

Added by Acts 2012, No. 96, § 1.

§ 1807.2. Rules and regulations

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 registration of appraisers for fire and extended coverage.

Added by Acts 2012, No. 96, § 1.

§ 1807.3. Enforcement

The commissioner is hereby authorized to take whichever actions are necessary or appropriate to enforce the provisions of this Part and the commissioner's regulations. The commissioner may order a person to cease and desist from committing violations of this Part or the commissioner's regulations or may issue an order prohibiting a person from acting as an appraiser and may rescind the registration of any person, if the person has violated this Part or the commissioner's regulations or orders.

Added by Acts 2012, No. 96, § 1.

CHAPTER 6. PAYMENT OF CLAIMS

PART I. LIFE INSURANCE CLAIMS PAYMENTS

§ 1811. 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.

Renumbered from R.S. 22:656 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1980, No. 477, § 1.

PART II. HEALTH AND ACCIDENT INSURANCE CLAIMS PAYMENTS

SUBPART A. HEALTH AND ACCIDENT INSURANCE CLAIMS PAYMENT—GENERAL PROVISIONS

§ 1821. 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 of this Section, 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 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; 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 that 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; such 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) of this Paragraph 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. 22:1969.

(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 either of the following:

(i) Previously certified or approved health care or medical services as contracted for between the insurer and insured.

(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 do any of the following:

(i) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure.

(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 (a) of this Paragraph.

(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.

(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.

(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, 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 limited benefit health insurance policies or contracts authorized to be issued in the state.

G. Repealed by Acts 1999, No. 1017, § 2, eff. July 9, 1999.

Renumbered from R.S. 22:657 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2012, No. 271, § 1.

§ 1822. Proceeds from health care payments; notice to patient, creditor

A. Any entity, including a health care provider as defined by R.S. 40:1231.1, 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.

Renumbered from R.S. 22:674 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1385, § 1.

§ 1823. 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.

Renumbered from R.S. 22:659 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1958, No. 246, § 1. Amended by Acts 1968, No. 462, § 1; Acts 1980, No. 822, § 1.

§ 1824. 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. Repealed by Acts 2012, No. 271, § 2.

Renumbered from R.S. 22:11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 653, § 1. Amended by Acts 2001, No. 1178, § 2, eff. June 29, 2001.

§ 1825. 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,[1] 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 of this Section 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 of this Section 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 and 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.

Renumbered from R.S. 22:12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 664, § 1. Amended by Acts 2012, No. 271, § 1.

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

§ 1826. Payment of claims for emergency services provided by noncontracted health care providers

A. If a health care provider that does not contract with a health insurance issuer files a claim with a health insurance issuer for emergency services rendered, the health insurance issuer shall directly pay such a claim by a noncontracted provider in the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer, less any amount representing coinsurance, copayments, deductibles, noncovered services, or any other amounts identified by the health insurance issuer pursuant to the plan or policy provisions, as an amount for which the insured or enrollee is liable. Payment of such claim by the health insurance issuer shall in no circumstances be made directly to the patient, insured, or enrollee.

B. For purposes of this Section, "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. The term shall also include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, and nonfederal government plans subject to the provisions of Subpart B of this Part and the Office of Group Benefits.

C. The provisions of this Section shall not apply to limited benefit health insurance policies or contracts.

Added by Acts 2010, No. 340, § 1, eff. Nov. 15, 2010.

§ 1827. Submission of health insurance claims

A. No healthcare provider that accepts a patient's health insurance coverage shall require an enrollee or insured to consent to payment for healthcare services as a condition for verification of health insurance coverage for such healthcare services.

B. For purposes of this Section:

(1) "Healthcare services" means services, items, supplies, or drugs for the

diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(2) "Health insurance coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise, and includes healthcare services paid for under any plan, policy, or certificate of insurance.

(3) "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 Subpart, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of this Part, and the Office of Group Benefits.

C. Any provision in an agreement between a provider of healthcare services and a health insurance issuer that conflicts with the provisions of this Section shall be deemed null and void.

Added by Acts 2014, No. 555, § 1.

SUBPART B. MEDICAL CLAIMS

§ 1831. Definitions

As used in this Subpart, 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 Subpart.

(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 Subpart, a "health insurance issuer" or "issuer" shall include but not be limited to a health maintenance organization as defined and licensed pursuant to Subpart I of Part I 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.

Renumbered from R.S. 22:250.31 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999. Amended by Acts 2001, No. 1096, § 1; Acts 2001, No. 1198, § 1, eff. June 29, 2001; Acts 2005, No. 273, § 1, eff. Jan. 1, 2006.

§ 1832. 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 Subpart. 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 Subpart shall not apply to the Office of Group Benefits.

Renumbered from R.S. 22:250.32 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999. Amended by Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2005, No. 273, § 1, eff. Jan. 1, 2006.

§ 1833. 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 Subpart shall not apply to the Office of Group Benefits.

Renumbered from R.S. 22:250.33 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999. Amended by Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2005, No. 273, § 1, eff. Jan. 1, 2006.

§ 1834. Remittance advice; thirty-day payment standard; limitations on claim filing and audits; limitations on retroactive denial and recoupment

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. 22:1832 and 1833 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 Subpart.

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. 22:1832 or 1833 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.

E. Notwithstanding any other provision of law to the contrary, for health services rendered in good faith and pursuant to the benefit plan, no health insurance issuer shall retroactively deny payment or recoup any monies paid beyond ninety days from the expiration of the allowable thirty-day period for the payment of any claim when the denial or recoupment is based on a determination that the insured was no longer covered under the plan at the time of the service.

F. The provision described in Subsection E of this Section shall not apply to the Office of Group Benefits or to the claims of Office of Group Benefits enrollees administered by health insurance issuers.

G. In order to be eligible for credit of premium by a health insurance issuer, an employer that contracts with a health insurance issuer for the issuer's provision or administration of health benefits shall provide notice to the health insurance issuer that an employee, dependent, or retiree is no longer eligible for coverage in the group benefit plan within ninety days of such ineligibility.

Renumbered from R.S. 22:250.34 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999. Amended by Acts 2001, No. 1198, § 1, eff. June 29, 2001; Acts 2005, No. 273, § 1, eff. Jan. 1, 2006; Acts 2008, No. 575, § 1, eff. Jan. 1, 2009.

§ 1835. 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 Subpart. 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 Subpart.

C. The provisions of this Subpart shall not supersede the provisions of Subpart C of Part II of this Chapter.

Renumbered from R.S. 22:250.35 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999. Amended by Acts 2005, No. 273, § 1, eff. Jan. 1, 2006.

§ 1836. 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 Subpart.

(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 Subpart 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.

Renumbered from R.S. 22:250.36 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999.

§ 1837. 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 Subpart, he shall notify such issuer in accordance and compliance with R.S. 49:961 and, after notice 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 Subpart, 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 Subpart. 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 compliance with R.S. 49:961, 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.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:250.37 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 1017, § 1, eff. July 9, 1999. Amended by Acts 2001, No. 1178, § 2, eff. June 29, 2001; Acts 2009, No. 317, § 1.

§ 1838. 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.

Renumbered from R.S. 22:250.38 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 1096, § 1. Amended by Acts 2003, No. 672, § 1.

SUBPART C. PHARMACY AND PHARMACIST CLAIMS

§ 1851. 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 Subpart shall be interpreted to achieve these ends.

Renumbered from R.S. 22:250.51 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005.

§ 1852. Definitions

As used in this Subpart, the following terms shall be defined as follows:

(1) "Claim" means a request by a pharmacist for payment by a health insurance issuer.

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

(3) "Department" means the Department of Insurance.

(4) "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.

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

(6) "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.

(7) "Health insurance issuer" means an insurance company, including a health

maintenance organization as defined and licensed pursuant to Subpart I of Part I 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 Subpart, a "health insurance issuer" shall include the Office of Group Benefits.

(8) "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.

(9) "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.

(10) "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.

(11) "Remittance advice" means a written or electronic communication explaining the health insurance issuer's action on each claim adjudicated by the issuer. Such communication is sent by a health insurance issuer or its agent to a retail or mail order pharmacist or his agent or retail or mail order pharmacy or its agent.

(12) "Uniform claim form" shall mean a form prescribed by rule by the department pursuant to R.S. 22:1824.

Renumbered from R.S. 22:250.52 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005. Amended by Acts 2005, No. 209, § 1, eff. July 1, 2005; Acts 2008, No. 755, § 1, eff. July 1, 2009.

Effective Date; Contracts for Payment of Claim—Acts 2008, No. 755

Section 2 of Acts 2008, No. 755 (§ 1 of which added pars. (10) to (12) of this section) provides:

"Section 2. This Act shall become effective on July 1, 2009. Any contract for payment of a claim in effect on July 1, 2009, shall be subject to the provisions of this Act."

§ 1853. 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 Subpart. 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.

Renumbered from R.S. 22:250.53 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005.

§ 1854. 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.

Renumbered from R.S. 22:250.54 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005. Amended by Acts 2005, No. 209, § 1, eff. July 1, 2005.

§ 1855. Submission to health insurance issuer

A. For purposes of R.S. 22:1853, 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. 22:1854, 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.

Renumbered from R.S. 22:250.55 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005.

§ 1856. Thirty-day payment standard; limitations on claim filing and audits; remittance advice

A. A health insurance issuer may elect to utilize a thirty-day payment standard for compliance with R.S. 22:1853 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 Subpart.

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. 22:1853 or 1854 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.

C. Each remittance advice generated by a health insurance issuer or its agent to a pharmacist or his agent or pharmacy or its agent shall be postmarked within seven business days of payment and shall include the following information, clearly identified and totaled for each claim listed:

(1) Unique enrollee or insured identification number.

(2) Patient claim number or patient account number.

(3) Date that the prescription was filled.

(4) National Drug Code.

(5) Quantity dispensed.

(6) Price submitted to the health insurance issuer or its contractor.

(7) Amount paid by the health insurance issuer or its contractor.

(8) Dispensing fee.

(9) Provider fee.

(10) Taxes.

(11) Enrollee or insured liability, specifying any coinsurance, deductible, copayment, or noncovered amount.

(12) Any amount adjusted by the health insurance issuer or its contractor and the reason for adjustment.

(13) Any other deduction or charge, listed separately.

(14) A toll-free telephone number for assistance with the remittance advice.

D. The provisions of Subsection C of this Section shall not be construed to require the adoption of any particular form of remittance advice which is otherwise in compliance with the provisions of this Section.

E. No remittance advice shall contain any information that would cause a violation of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320 et seq.). All electronic remittance advices shall follow the ANSI X12N 835 HIPAA Standard Transaction file format or any subsequent standards that are required.

F. No health insurance issuer or its agent shall unilaterally determine the amount of any processing fee on each claim but shall decide that amount in conjunction with the affected pharmacist or pharmacy.

Renumbered from R.S. 22:250.56 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005. Amended by Acts 2008, No. 755, § 1, eff. July 1, 2009; Acts 2010, No. 467, § 1, eff. Jan. 1, 2011.

Effective Date; Contracts for Payment of Claim—Acts 2008, No. 755

Section 2 of Acts 2008, No. 755 (§ 1 of which added subsecs. C to E of this section) provides:

"Section 2. This Act shall become effective on July 1, 2009. Any contract for payment of a claim in effect on July 1, 2009, shall be subject to the provisions of this Act."

§ 1856.1. Pharmacy record audits; recoupment; appeals

A. As used in this Section, "entity" means a managed care company, insurance company, third-party payor, or the representative of the managed care company including a pharmacy benefit manager, insurance company, or third-party payor.

B. Notwithstanding any other provision of law to the contrary, when an onsite audit of the records of a pharmacy is conducted by an entity, the audit shall be conducted in accordance with the following criteria:

(1) The audit may not take place during the first five days of the month.

(2) No entity shall conduct an on-site audit at a particular pharmacy more than one time annually. However, the provisions of this Paragraph shall not apply when an entity must return to a pharmacy to complete an audit already in progress, or there is an identified history of errors, an identified activity which a reasonable man would believe to be inappropriate, or illegal activity that the entity has brought to the attention of the pharmacy owner or corporate headquarters of the pharmacy.

(3)(a) The entity or any vendor or subcontractor of the entity which conducts the initial onsite audit shall give the pharmacy notice at least two weeks before conducting the initial onsite audit for each audit cycle.

(b) If the audit, review, or investigation is initiated based on or involves alleged fraud or willful misrepresentation, notice before the initial on-site audit is not mandatory where it could impede the audit, review, or investigation.

(4)(a)(i) Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record shall not necessarily constitute fraud.

(ii) A claim arising pursuant to the provisions of this Section may be subject to recoupment.

(b) No claim arising pursuant to the provisions of this Section shall be subject

to criminal penalties without proof of intent to commit fraud.

(5) A pharmacy may provide the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of supporting the pharmacy record with respect to orders or refills of a legend or narcotic drug.

(6) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity.

(7)(a) The preliminary audit report shall be delivered to the pharmacy within ninety days after conclusion of the audit.

(b) A pharmacy shall be allowed at least thirty days following receipt of the preliminary audit report in which to initiate an appeal to address any discrepancy found during an on-site audit, as provided in Subsection E of this Section.

(c) A final audit report shall be delivered to the pharmacy within one hundred twenty days after receipt of the preliminary audit report or notice of appeal, whichever is later.

(d) Each entity conducting an audit shall make available a copy of the final audit report to the plan sponsor upon request or as otherwise required by contractual agreement.

(8) Any audit which involves clinical judgment shall be conducted by or in consultation with a licensed pharmacist.

(9) Interest on recoupment debts shall not accrue during the audit or appeal period.

(10) If the audit is conducted by a vendor or subcontractor of an entity, the vendor or subcontractor shall identify to the pharmacy the entity on whose behalf the audit is being conducted without necessity of this information being requested by the pharmacy.

(11) The audit shall be based only on information obtained by the entity conducting the audit and not based on any audit report or other information gained from an audit conducted by a different auditing entity. Nothing in this Paragraph shall prohibit an auditing entity from using an earlier audit report prepared by that auditing entity for the same pharmacy. Except as required by state or federal law, an entity conducting an audit may have access to a pharmacy's previous audit report only if the previous report was prepared by that entity.

C. (1) Recoupment of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur after final disposition of the audit, including the appeals process. Recoupment shall not be based on documentation requirements in addition to or exceeding requirements for creating or maintaining documentation prescribed by the Louisiana Board of Pharmacy; or on a requirement that a pharmacy or pharmacist perform a professional duty in addition to or exceeding professional duties prescribed by the Louisiana Board of Pharmacy.

(2) The provisions of this Section shall not apply in cases of United States Food and Drug Administration regulation or manufacturer safety programs.

(3)(a) The full amount of any recoupment on an audit shall be refunded to the responsible party.

(b) Except as provided in this Subsection, a charge or assessment for an audit shall not be based, directly or indirectly, on amounts recouped.

(c) Nothing in this Subsection shall be construed to prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(i) The responsible party and the entity have a contract that explicitly states the percentage charge or assessment to the responsible party.

(ii) A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

(4) Before recoupment of funds may be made based on an audit finding overpayment or underpayment, a final audit report shall be distributed.

D. (1) No pharmacy shall be subject to recoupment of any portion of the reimbursement for the dispensed product of a prescription unless one or more of the following has occurred:

(a) The pharmacy has engaged in fraudulent activity or other intentional and willful misrepresentation, as evidenced by a review of claims data or statements, physical review, or any other investigative method.

(b) The pharmacy has engaged in dispensing in excess of the benefit design, as established by the plan sponsor.

(c) The pharmacy has not filled prescriptions in accordance with the prescriber's order.

(d) The pharmacy has received an actual overpayment.

(2) Recoupment of claims shall be based on the actual financial harm to the entity or on the actual overpayment or underpayment. A finding of an overpayment that is the result of dispensing in excess of the benefit design, as established by the plan sponsor, shall be calculated as the difference between what was dispensed in accordance with the prescriber's orders and the dispensing requirements as set forth by the benefit design. Calculations of overpayments shall not include dispensing fees unless one or more of the following conditions has been satisfied:

(a) A prescription was not actually dispensed.

(b) The prescriber denied authorization.

(c) The prescription dispensed was a medication error by the pharmacy.

(d) The identified overpayment is based solely on an extra dispensing fee.

(e) The pharmacy was noncompliant with program guidelines.

(f) There was insufficient documentation.

E. (1) Each entity conducting an audit shall establish an appeal process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(2) If, following an appeal, the entity finds that an unfavorable audit report or any portion of an unfavorable audit report is unsubstantiated, the entity shall dismiss the audit report or the unsubstantiated portion of the audit report without any further proceedings.

(3) No interest shall be charged to the entity during the appeal period.

(4) Following the final audit report, and if not otherwise provided for in the provider contract, either party may seek mediation to address outstanding disagreements.

(5) Notwithstanding any other provision of law to the contrary, the agency conducting the audit shall not use the accounting practice of extrapolation in calculating recoupment or penalties for audits, unless otherwise agreed to by the pharmacy or mandated by a government agency or in the case of fraud.

F. Unless otherwise provided for in the network agreement, pharmacies or payors may seek mediation to resolve contractual disputes related to pricing or on-site audits.

G. This Section shall not apply to:

(1) Any quality assurance review, as defined by the time period prior to the reimbursement by the entity to the pharmacy.

(2) An investigation that is initiated based on or that involves suspected or alleged fraud, willful misrepresentation, or abuse.

(3) Any federally funded activity specifically preempted by law or rule.

(4) Any audit conducted pursuant to the participation of a pharmacy in the Louisiana Medicaid Program.

Added by Acts 2012, No. 856, § 1. Amended by Acts 2014, No. 502, § 1, eff. June 5, 2014.

Application—Acts 2012, No. 856

Section 2 of Acts 2012, No. 856 (§ 1 of which added this section) provides:

"Section 2. The provisions of this Act shall apply to contracts entered into, amended, extended, or renewed on or after January 1, 2013."

§ 1857. 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. 22:1854(C) to the extent of any amount not paid in accordance with the requirements of this Section.

Renumbered from R.S. 22:250.57 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005. Amended by Acts 2005, No. 209, § 1, eff. July 1, 2005.

§ 1857.1. Third-party contracts with pharmacies

A. Notwithstanding any provision of law to the contrary, an organization that negotiates with a pharmacy or pharmacies, and an organization that represents an independent pharmacy or a group of independent pharmacies, shall provide to each pharmacy that the organization represents a copy of any new contract, provider agreement, amendment to such contract or agreement, or other provider documentation concerning the pharmacy's network participation with a third-party payor.

B. In addition to the penalties provided in R.S. 22:1860, any violation of the provisions of Subsection A of this Section shall be deemed an unfair or deceptive act and practice pursuant to R.S. 22:1961 et seq. and shall be subject to the penalties provided therein.

Added by Acts 2014, No. 490, § 1.

§ 1858. 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 Subpart.

(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.

Renumbered from R.S. 22:250.58 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005.

§ 1859. 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.

Renumbered from R.S. 22:250.59 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005. Amended by Acts 2012, No. 271, § 1.

§ 1860. 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 Subpart, he shall notify such issuer in accordance and compliance with R.S. 49:961 and, after notice, 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 Subpart, 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 Subpart. 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 and in accordance with R.S. 49:961 while such order is in effect shall, after notice, 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.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:250.60 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005. Amended by Acts 2005, No. 209, § 1, eff. July 1, 2005; Acts 2009, No. 317, § 1.

§ 1860.1. Reimbursement of pharmacy provider fee; sanctions; administrative hearings

A. It is the obligation of a health insurance issuer or its agent to reimburse a pharmacist or his agent for fees remitted by a pharmacy or pharmacist or his agent in compliance with R.S. 46:2625.

B. The failure to reimburse a pharmacy or pharmacist or his agent by a health insurance issuer or its agent for the fees authorized in R.S. 46:2625(A)(1) shall be an act for which the health insurance issuer or its agent may be sanctioned by the commissioner in accordance with R.S. 22:1860. Any person sanctioned pursuant to this Section may demand an administrative hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Added by Acts 2015, No. 399, § 1.

§ 1861. Regulations

The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Subpart. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act.

Renumbered from R.S. 22:250.61 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005.

§ 1862. Applicability

The provisions of Subpart B of Part II of this Chapter, R.S. 22:1831 et seq., shall not apply to this Subpart.

Renumbered from R.S. 22:250.62 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 876, § 1, eff. Jan. 1, 2005.

SUBPART C-1. PHARMACY BENEFIT MANAGER'S MAINTENANCE AND USE OF MAXIMUM ALLOWABLE COST LISTS FOR PRESCRIPTION DRUGS

§ 1863. Definitions

As used in this Subpart, the following definitions shall apply:

(1) "Maximum Allowable Cost List" means a listing of the National Drug Code used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist may be based.

(2) "NDC" means the National Drug Code, a numerical identifier assigned to all prescription drugs.

(3) "Pharmacist" means a licensed pharmacist as defined in R.S. 22:1852(8).

(4) "Pharmacist services" means products, goods, or services provided as a part of the practice of pharmacy as defined in R.S. 22:1852(9).

(5) "Pharmacy" means any appropriately licensed place where prescription drugs are dispensed as defined in R.S. 22:1852(10).

(6) "Pharmacy benefits manager" means an entity that administers or manages a pharmacy benefits plan or program.

(7) "Pharmacy benefits plan" or "pharmacy benefits program" means a plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in Louisiana.

Added by Acts 2014, No. 391, § 1.

§ 1864. Requirements for use of the National Drug Code by a pharmacy benefits manager

A. Before a pharmacy benefits manager places or continues a particular NDC or Maximum Allowable Cost List, the following requirements shall be met:

(1) The prescription drug to which the NDC is assigned shall be listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or have an "NR" or "NA" rating or a similar rating by a nationally recognized reference.

(2) The prescription drug to which the NDC is assigned shall be available for purchase by pharmacies in the state from national or regional wholesalers.

(3) The prescription drug to which the NDC is assigned shall not be considered obsolete.

B. A pharmacy benefits manager shall be required to:

(1) Provide access to its Maximum Allowable Cost List to each pharmacy subject to the list.

(2) Update its Maximum Allowable Cost List on a timely basis, but in no event longer than seven calendar days from a change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology.

(3) Provide a process for each pharmacy subject to the list to review an update to the Maximum Allowable Cost List.

Added by Acts 2014, No. 391, § 1.

§ 1865. Appeals

A. The pharmacy benefits manager shall provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs for a specific NDC or NDCs as not meeting the requirements of this Subpart or being below the cost at which the pharmacy may obtain the NDC. Within seven business days after the applicable fill date, a pharmacy may file an appeal by following the appeal process as provided for in this Subpart. The pharmacy benefits manager shall respond to a challenge within seven business days after receipt of the challenge.

B. If an appeal made pursuant to this Section is upheld, the pharmacy benefits manager shall take the following actions:

(1) Make the change in the Maximum Allowable Cost List.

(2) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question.

(3) Make the change effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List.

C. If an appeal made pursuant to this Section is denied, the pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the NDC number from national or regional wholesalers operating in Louisiana.

D. A violation of this Subpart shall be deemed an unfair or deceptive act and practice pursuant to R.S. 22:1961 et seq.

Added by Acts 2014, No. 391, § 1.

SUBPART D. HEALTH CARE CONSUMER BILLING AND DISCLOSURE PROTECTION ACT

§ 1871. Short title

This Subpart shall be known and may be cited as the "Health Care Consumer Billing and Disclosure Protection Act".

Renumbered from R.S. 22:250.41 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004.

§ 1872. Definitions

As used in this Subpart:

(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. 22:1122.

(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 Subpart, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of this Part, 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.

Renumbered from R.S. 22:250.42 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004.

§ 1873. 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 Subpart.

(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.

Renumbered from R.S. 22:250.43 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004. Amended by Acts 2004, No. 607, § 1.

§ 1874. 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 Subpart.

(5)(a) Under certain circumstances and when the provisions of Subparagraph (b) of this Paragraph are met, a health insurance issuer contracting with a group of physicians that bills a health insurance issuer utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR162.402 et seq., shall pay the contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group, without health care provider credentialing as described in R.S. 22:1009. This provision shall apply in either of the following circumstances:

(i) When the new physician has already been credentialed by the health insurance

issuer and the physician's credentialing is still active with the issuer.

(ii) When the health insurance issuer has received the required credentialing application and information, including proof of active hospital privileges, from the new physician and the issuer has not notified the physician group that credentialing of the new physician has been denied.

(b) A health insurance issuer shall comply with the provisions of Subparagraph (a) of this Paragraph no later than thirty days after receipt of a written request from the physician group. The written request shall include a statement that the physician group agrees that all contract provisions, including the provision holding covered persons harmless for charges beyond reimbursement by the issuer and deductible, coinsurance and copayments, apply to the new physician. Such compliance shall apply to any claims for covered services rendered by the new physician to covered persons on dates of service no earlier than the date of the written request from the physician group.

(c) Compliance by a health insurance issuer with the provisions of Subparagraph (a) of this Paragraph shall not be construed to mean that a physician has been credentialed by an issuer or that the issuer is required to list the physician in a directory of contracted physicians.

(d) If, upon compliance with Subparagraph (a) of this Paragraph, a health insurance issuer completes the credentialing process on the new physician and determines that the physician does not meet the issuer's credentialing requirements, the following actions shall be permitted:

(i) The health insurance issuer may recover from the physician or the physician group an amount equal to the difference between appropriate payments for in-network benefits and out-of-network benefits provided that the health insurance issuer has notified the applicant physician of the adverse determination and provided that the health insurance issuer has initiated action regarding such recovery within thirty days of the adverse determination.

(ii) The physician or the physician group may retain any deductible, coinsurance or copayment collected or in the process of being collected as of the date of receipt of the issuer's determination, so long as the amount is not in excess of the amount owed by the insured or enrollee for out-of-network services.

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.

Renumbered from R.S. 22:250.44 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004. Amended by Acts 2010, No. 897, § 1, eff. Jan. 1, 2011.

§ 1875. 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 in this Subpart shall supercede the provisions of R.S. 22:263(D).

Renumbered from R.S. 22:250.45 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004. Amended by Acts 2012, No. 271, § 1.

§ 1876. 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. 22:1874(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.

Renumbered from R.S. 22:250.46 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004.

§ 1877. 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. 22:1874(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. 22:1873 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. 22:1874(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. 22:1874(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. 22:1871 through 1876 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. 22:1875 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.

Renumbered from R.S. 22:250.47 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1157, § 1, eff. Jan. 1, 2004.

§ 1878. 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.

Renumbered from R.S. 22:250.48 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 607, § 1.

§ 1879. Louisiana consumer health care provider network disclosure

A. (1) Within thirty days of the effective date of a new contract, each hospital or ambulatory surgical center, hereinafter referred to as "facility" or "contracted facility" for purposes of this Section, shall provide to each health insurance issuer with which it contracts, the National Provider Identifier (NPI) as set forth in 45 CFR § 162.402 et seq., name, business address, and business telephone number of each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at that facility. Thereafter, the facility shall notify each health insurance issuer of any changes to the information as soon as possible but not later than thirty days following any change.

(2) Within thirty days of the effective date of a new contract, each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at a contracted facility shall provide the health insurance issuer with which it is contracted, the NPI, name, business address, and business telephone number of each group or individual so contracted. Thereafter, the group or individual so contracted shall notify each health insurance issuer of any changes to the information as soon as possible but not later than thirty days following any change.

B. (1) Based on information received pursuant to Paragraphs (A)(1) and (2) of this Section, a health insurance issuer shall report on its website in a format

that is clear and easy for its enrollees to understand, the following information arranged by contracted facility:

(a) Facility name, address, and phone number.

(b) The names, business addresses and business telephone numbers of each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at that facility and who are contracted with the health insurance issuer.

(2) For each specialty at each contracted facility, there shall be a clear indication when the health insurance issuer has no contract in place with any of the individuals or groups of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at that contracted facility.

(3) A health insurance issuer shall update its website as soon as possible but not later than thirty days following receipt of any updated information or within thirty days of the effective date of a contract.

C. A health insurance issuer shall provide a link to its website containing the information described in Subsection B of this Section to the Department of Insurance. The Department of Insurance shall make the links received from health insurance issuers available on its website.

D. Except as otherwise provided in Subsection G of this Section, the Department of Insurance may promulgate rules and regulations to provide for civil fines payable by a health insurance issuer not to exceed five hundred dollars for each and every act of violation of the requirements of this Section, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.

E. The Department of Health and Hospitals may promulgate rules and regulations to provide for civil fines payable by a health care provider not to exceed five hundred dollars for each and every act of violation of the requirements of this Section, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.

F. A health insurance issuer that reports information received from a health care provider shall indemnify and hold the health care provider harmless for the nonintentional erroneous or incomplete information provided by the health care provider to the health insurance issuer under the provisions of this Section. A health care provider that provides information to a health insurance issuer under the provisions of this Section shall indemnify and hold the health insurance issuer harmless for nonintentional erroneous or incomplete information reported by the health insurance issuer under the provisions of this Section. The penalties under this Section shall be the exclusive remedy for any violations and there shall be no independent cause of action by any person based upon such violation or other information reported hereunder.

G. The provisions of this Section shall apply to the Office of Group Benefits; however, the commissioner of insurance shall not be authorized to levy a fine against the Office of Group Benefits. If the commissioner of insurance concludes

that the Office of Group Benefits has violated this Section, the commissioner of insurance shall notify the commissioner of administration in writing within sixty days of such violation.

Added by Acts 2009, No. 354, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1880. Balance billing disclosure

A. Definitions. As used in this Section, the following terms shall be defined as follows:

(1) "Balance billing" means any written or electronic communication by a non-contracted health care provider that appears to attempt to collect from an enrollee or insured any amount for covered, non-covered, and out-of-network health care services received by the enrollee or insured from the non-contracted health care provider that is not fully paid by the enrollee or insured, or the health insurance issuer.

(2) "Enrollee or insured liability" means the financial liability of an enrollee or insured for covered, non-covered, and out-of-network 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, "enrollee or insured liability" is the amount due for coinsurance, co-payments, deductibles, non-covered services, 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 or non-covered service.

(b) In the case of a non-contracted health care provider, "enrollee or insured liability" is the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer for covered and non-covered, out-of-network health care services, including but not limited to the enrollee's or insured's contractual deductible, coinsurance, or co-payment amount.

B. (1) Health insurance issuer disclosure requirements. Each health insurance issuer shall provide the following balance billing disclosure notice:

"NOTICE

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN".

(2) The balance billing disclosure notice shall be disclosed in all of the following methods:

(a) To the potential policyholder prior to the time the health benefit plan is purchased. The disclosure notice may be provided directly by the health insurance issuer or through an authorized insurance producer. If the health insurance issuer provides the disclosure notice to the producer, then the producer shall provide that disclosure notice to the potential policyholder.

(b) To the policyholder and enrollees, at the time the insurance policy or other proof of coverage is issued, as follows:

(i) For a group benefit plan, to the policyholder and employees at the time the insurance policy or other proof of insurance coverage is issued.

(ii) For an individual benefit plan, to the policyholder at the time the insurance policy or other proof of insurance coverage is issued.

(c) To the policyholder and enrollees at least once a year as follows:

(i) For a group benefit plan, to the policyholder and employees.

(ii) For an individual benefit plan, to the policyholder.

(d) On the health insurance issuer's website.

C. Facility disclosure requirements. Each health care facility shall:

(1) Provide a written notice to an enrollee or insured at the first registration contact with the enrollee or insured at the health care facility regarding nonemergency services disclosing the following items:

(a) Confirmation as to whether the facility is a participating provider contracted with the enrollee's or insured's health insurance issuer on the date services are to be rendered, based on the information received from the enrollee or insured at the time the confirmation is provided.

(b) The following balance billing disclosure notice:

"NOTICE

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN".

(2) Provide a list upon request from an enrollee or insured that contains the name and contact information for each individual or group of hospital-contracted anesthesiologists, pathologists, radiologists, hospitalists, intensivists, and neonatologists who provide services at that facility and inform the enrollee or insured that the enrollee or insured may request information from their health insurance issuer as to whether those physicians are contracted with the health insurance issuer and under what circumstances the enrollee or insured may be

responsible for payment of any amounts not paid by the health insurance issuer.

(3) If the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, post on the facility's website a list that contains the name and contact information for each facility-based physician or facility-based physician group that has been granted medical staff privileges to provide medical services at the facility, and an update of the list within thirty days of any changes.

D. Facility-based physician disclosure requirements. Whenever a facility-based physician bills a patient who has health insurance coverage issued by a health insurance issuer that does not have a contract with the facility-based physician, the facility-based physician shall send a bill that includes all of the following items:

(1) An itemized listing of the services and supplies provided by the facility-based physician along with the dates such services and supplies were provided.

(2) The amount that is owed by the enrollee or insured and language conspicuously displayed on the front of such bill:

"NOTICE: THIS IS A BILL. BASED UPON INFORMATION FROM YOUR HEALTH PLAN, YOU OWE THE AMOUNT SHOWN".

(3) A telephone number to call to discuss the statement.

Added by Acts 2010, No. 453, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1881. Reimbursement of monies paid to health insurers under automobile medical payment provisions; limitation on amounts reimbursed

A. Except as provided in this Section or by agreement between the parties and in accordance with regulations of the Department of Insurance governing the coordination of benefits, no health insurance issuer shall seek reimbursement from an insurer that provides automobile medical payment coverage to the health insurance issuer's insured or member without obtaining the prior written consent of the insured or member or his legal representative. After a period of nine months from the date of the accident from which medical claims arise, the health insurance issuer may seek reimbursement from the medical payments insurer for only the outstanding balance remaining under the automobile policy for medical coverage.

B. The provisions of this Section shall not prohibit or impair the rights of an insurer or provider from seeking reimbursement of monies paid pursuant to an insurance policy, plan, or self-insurance fund provided the total amount to be reimbursed shall not exceed the amount actually paid by the insurer or provider.

C. The provisions of this Section shall not apply to Medicare Advantage plans or self-insured plans.

Added by Acts 2011, No. 382, § 1.

PART III. PROPERTY AND CASUALTY INSURANCE CLAIMS PAYMENTS

§ 1891. 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.

Renumbered from R.S. 22:636.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 807, § 1.

§ 1892. Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; extension of time to respond to claims during emergency or disaster; penalties; arson-related claims suspension

A. (1) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, 1821, 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. The insurer shall notify the insurance producer of record of all such payments for property damage claims made in accordance with this Paragraph.

(2) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, R.S. 22:1821, 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 except that the commissioner may promulgate a rule for extending the time period for initiating a loss adjustment for damages arising from a presidentially declared emergency or disaster or a gubernatorially declared emergency or disaster up to an additional thirty days. Thereafter, only one additional extension of the period of time for initiating a loss adjustment may be allowed and must be approved by the Senate Committee on Insurance and the House Committee on Insurance, voting separately. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in R.S. 22:1973.

(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) of this Section, respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2) of this Section 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 fifty 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, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as reasonable attorney fees and costs. 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.

(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.

(5) When an insurance policy provides for the adjustment and settlement of first-party motor vehicle total losses on the basis of actual cash value or replacement with another of like kind and quality, and the insurer elects a cash settlement based on the actual cost to purchase a comparable motor vehicle, such costs shall be derived by using one of the following:

(a) A fair market value survey conducted using qualified retail automobile dealers in the local market area as resources. If there are no dealers in the local market area, the nearest reasonable market can be used.

(b) The retail cost as determined from a generally recognized used motor vehicle industry source; such as, an electronic database, if the valuation documents generated by the database are provided to the first-party claimant, or a guidebook

that is available to the general public. If the insured demonstrates, by presenting two independent appraisals, based on measurable and discernable factors, including the vehicle's preloss condition, that the vehicle would have a higher cash value in the local market area than the value reflected in the source's database or the guidebook, the local market value shall be used in determining the actual cash value.

(c) A qualified expert appraiser selected and agreed upon by the insured and insurer. The appraiser shall produce a written nonbinding appraisal establishing the actual cash value of the vehicle's preloss condition.

(d) For the purposes of this Paragraph, local market area shall mean a reasonable distance surrounding the area where a motor vehicle is principally garaged, or the usual location of the vehicle covered by the policy.

C. (1) All claims brought by insureds, workers' 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; however, 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. 22:1554, for the commissioner to refuse to issue a license or to suspend or revoke a license issued to any producer to sell insurance in this state.

Renumbered from R.S. 22:658 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by 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; Acts 2003, No. 790, § 1; Acts 2006, No. 404, § 1; Acts 2006, No. 813, § 1; Acts 2009, No. 488, § 1; Acts 2010, No. 1032, § 1; Acts 2012, No. 271, § 1.

§ 1892.1. Arbitration or other type of binding mediation by automobile insurers

No automobile insurer shall use arbitration or any other type of binding mediation

to determine fault for purposes of settling a claim resulting from an automobile accident for the purpose of raising insurance premiums of an insured without notifying the insured as to the percentage of fault prior to arbitration.

Added by Acts 2010, No. 828, § 1, eff. June 1, 2010.

Application—Acts 2010, No. 828

Section 2 of Acts 2010, No. 828 (§ 1 of which enacted this section) provides:

"Section 2. The provisions of this Act shall only apply to automobile insurance policies and contracts issued or renewed on or after June 1, 2010."

§ 1893. Claims involving immovable property

A. (1) No insurer shall use the floodwater mark on a covered structure without considering other evidence, when determining whether a loss is covered or not covered under a homeowners' insurance policy.

(2) No insurer shall use the fact that a home is removed or displaced from its foundation without considering other evidence, when determining whether a loss is covered or not covered under a homeowners' insurance policy.

B. If damage to immovable property is covered, in whole or in part, under the terms of the policy of insurance, the burden is on the insurer to establish an exclusion under the terms of the policy.

C. Any clause, condition, term, or other provision contained in any policy of insurance which alters or attempts to alter the burden on an insurer as provided in Subsection B of this Section shall be null and void and of no effect.

D. Any insurer determined to be in violation of the provisions of this Section shall be liable pursuant to R.S. 22:1973.

Renumbered from R.S. 22:658.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 12, § 1, eff. Feb. 23, 2006.

§ 1894. Filing claims; extension for claims arising from hurricane activity

A. Notwithstanding any other provision of this Title to the contrary, any person or entity having a claim for damages pursuant to a homeowners' insurance policy, personal property insurance policy, tenant homeowners' insurance policy, condominium owners' insurance policy, or commercial property insurance policy, and resulting from Hurricane Katrina shall have through September 1, 2007, within which to file a claim with their insurer for damages, unless a greater time period to file such claim is otherwise provided by law or by contract.

B. Notwithstanding any other provision of this Title to the contrary, any person or entity having a claim for damages pursuant to a homeowners' insurance policy, personal property insurance policy, tenant homeowners' insurance policy, condominium owners' insurance policy, or commercial property insurance policy, and resulting from Hurricane Rita shall have through October 1, 2007, within which to file a claim with their insurer for damages, unless a greater time period to file such claim is otherwise provided by law or by contract.

Renumbered from R.S. 22:658.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 739, § 1, eff. June 29, 2006.

Declaratory Judgment Action; Validity—Acts 2006, No. 739

Section 3 of Acts 2006, No. 739 (§ 1 of which amended R.S. 22:629 and enacted this section [Act 739 did not contain a § 2]) provided:

"Section 3. The attorney general is hereby directed to file suit within ten days of the effective date of this Act seeking declaratory judgment to determine the constitutionality of the provisions of this Act or the constitutionality of Acts 2006, No. __ that originated as House Bill No. 1302 or Acts 2006, No.__ that originated as Senate Bill No. 740, and such suit shall seek to determine the constitutionality of any or all of these Acts."

House Bill No. 1302 was enacted and designated Acts 2006, No. 802, providing for the interruption of prescription for Hurricane Katrina and Hurricane Rita insurance claims. Senate Bill No. 740 did not become law.

For provisions of Acts 2006, No. 802, see C.C. art. 3467.

In the case of State of Louisiana v. All Property and Casualty Insurance Carriers Authorized and Licensed to do Business in the State of Louisiana, 937 So.2d 313 (La. 8/25/06), the Louisiana Supreme Court, exercising its supervisory authority in an expedited manner to determine the validity of Acts 2006, Nos. 739 and 802, declared them both to be constitutional.

§ 1895. Homeowner's insurance; claims payments and settlements

No payment of a claim on a homeowner's insurance policy shall be considered a final settlement if the insurer fails to provide the insured with a statement that accurately reflects the amount paid under each category of coverage under the policy. The statement shall list each provision of coverage in the policy under which the insured may be entitled to payment, the maximum amount that may be paid under each category of coverage, and the amount actually included for payment under each category of coverage. The statement shall be given to the insured prior to the execution of a release by the insured.

Renumbered from R.S. 22:1471.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2005, 1st Ex.Sess., No. 38, § 1, eff. Dec. 6, 2005.

§ 1896. Right to transparency and integrity in adjustment of property claims

A. An insurer of a residential or commercial property shall respond to all inquiries or requests from the insured within fourteen days of the inquiry or request, unless such time period to respond has been extended by the commissioner of insurance because of a disaster or emergency declared in accordance with R.S. 29:721 et seq.

B. An insurer of a residential or commercial property shall provide prompt adjustment by a qualified adjuster pursuant to the provisions of R.S. 22:1661 et seq., the Louisiana Claims Adjuster Act.

C. Any violations of this Section that are committed or performed with such frequency as to indicate a general business practice such as those enumerated in R.S. 22:1964(14) shall be subject to the provisions of R.S. 22:1964 et seq., the Unfair Trade Practices Act.

Renumbered from R.S. 22:1476 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 222, § 2, eff. July 2, 2007.

CHAPTER 7. FRAUD AND UNFAIR TRADE PRACTICES

PART I. UNAUTHORIZED INSURANCE

§ 1901. 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.

Renumbered from R.S. 22:1248 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1340, § 1, eff. July 15, 1997. Amended by Acts 2012, No. 271, § 1.

§ 1902. 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 applications, 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.

Renumbered from R.S. 22:1249 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1968, No. 52, § 1. Amended by Acts 1990, No. 885, § 1; Acts 1993, No. 663, § 2, eff. June 16, 1993; Acts 1997, No. 1340, § 1, eff. July 15, 1997; Acts 2012, No. 271, § 1.

§ 1903. 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, if 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. 22:436 or other insurers which have been affirmatively approved in writing by the commissioner and that satisfy the requirements of R.S. 22:435. 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.

Renumbered from R.S. 22:1249.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1340, § 1, eff. July 15, 1997. Amended by Acts 2012, No. 271, § 1.

§ 1904. 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.

Renumbered from R.S. 22:1250 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1968, No. 53, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1905. 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 provisions of Subsections A and B of this Section:

(1) Contracts entered into where the prospective insured 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.

Renumbered from R.S. 22:1251 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 144, § 1; Acts 1989, No. 449, § 1, eff. Sept. 1, 1989; Acts 2012, No. 271, § 1.

§ 1906. 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 workers' compensation claims office pursuant to R.S. 23:1161.1.

Renumbered from R.S. 22:1252 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1972, No. 238, § 1; Acts 1990, No. 885, § 1.

§ 1907. 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 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 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 if 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 compliance with this Section 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. (1) 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 as provided in Paragraph (2) of this Subsection upon any person within this state who, in this state on behalf of such insurer, is doing any of the following:

(a) Soliciting insurance.

(b) Making any contract of insurance or issuing or delivering any policies or written contracts of insurance.

(c) Collecting or receiving any premium for insurance.

(d) Acting as an agent for the sole purpose of operating a workers' compensation claims office established pursuant to R.S. 23:1161.1.

(2) A copy of such process shall be 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 compliance with this Section shall be 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.

D. Nothing in this Section shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner permitted by law.

Renumbered from R.S. 22:1253 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1968, No. 54, § 1; Acts 1990, No. 885, § 1; Acts 1999, No. 395, § 4; Acts 2012, No. 271, § 1.

§ 1908. 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.

Renumbered from R.S. 22:1254 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2003, No. 994, § 1, eff. July 2, 2003.

§ 1909. 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 R.S. 22:1907(B) or (C) may order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this Section and to defend such action.

C. Nothing in Subsection 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 R.S. 22:1907 (B) or (C) on the ground: (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; (2) that such insurer has not been transacting business in this state; or (3) that the person on whom service was made pursuant to R.S. 22:1907(C) was not doing any of the acts therein enumerated.

Renumbered from R.S. 22:1255 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2003, No. 994, § 1, eff. July 2, 2003; Acts 2012, No. 271, § 1.

§ 1910. 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.

Renumbered from R.S. 22:1256 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 1911. 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 order of the commissioner of insurance, 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, a person shall be liable for a fine of not more than five hundred dollars.

Added by Acts 2010, No. 107, § 1.

PART II. INSURANCE FRAUD

§ 1921. Purpose and powers

A. The purpose of this Part is to create within the Department of Insurance a division of insurance fraud. This division shall be charged with the responsibility, when directed by the commissioner of insurance, to conduct investigations and background criminal checks on each applicant for a license or certificate of authority to transact a business of insurance. The division of insurance fraud shall be governed by the provisions of this Part including the powers and duties relating to the investigation and prevention of administrative or civil violations of the insurance laws of this state.

B. In the event the applicant is a corporation, partnership, or other legal entity, the investigations and criminal background checks shall be limited to those individuals who are directors, officers, employees, or individuals who exercise control, as defined in R.S. 22:691.2(3), of the entity. After the receipt of a license or certificate of authority, an individual who intends to succeed to a position subject to this Subsection or to control, as defined in R.S. 22:691.2(3), the entity shall undergo an investigation and criminal background check.

C. If the division 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 this Code, it may examine and investigate the affairs of such person and may administer oaths and affirmations, serve subpoenas ordering the attendance of witnesses, and collect evidence.

D. If during the course of investigation, the division of insurance fraud determines that there may be a violation of criminal law, the division shall turn the matter over to the Department of Justice; the Department of Public Safety and Corrections, public safety services, office of state police; and any other appropriate law enforcement or prosecutorial agency, for further investigation, enforcement, or prosecution.

Renumbered from R.S. 22:1241 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 1994, 3rd Ex.Sess., No. 50, § 2; Acts 1999, No. 1312, § 2, eff. Jan. 1, 2000; Acts 2004, No. 826, § 1; Acts 2012, No. 192, § 1; Acts 2012, No. 271, § 1; Acts 2013, No. 217, § 1; Acts 2015, No. 162, § 1, eff. June 23, 2015.

§ 1922. Additional powers and duties

A. The division of insurance fraud shall have access to computer systems, information maintained for the use of law enforcement personnel, any information contained in the criminal history record and identification file of the Louisiana Bureau of Criminal Identification and Information, and direct and timely access to information compiled by the Federal Bureau of Investigation, as contained in the National Crime Information Center, for the purposes of carrying out its responsibilities under this Part.

B. The commissioner may require each applicant for a license or certificate of authority to submit fingerprints to verify the identity of the applicant. An applicant's fingerprints shall be made electronically or by ink and converted to electronic format. The commissioner may promulgate rules and regulations defining the manner in which such evidence is to be received by the Department of Insurance.

C. In order to make a determination of eligibility, the commissioner is authorized to require fingerprints and fees of applicants and to submit the fingerprints and the fee required to perform the criminal history record checks to the Louisiana Bureau of Criminal Identification and Information and the Federal Bureau of Investigation ("FBI") for state and national criminal history record checks. The commissioner shall require a criminal history record check on each applicant in accordance with this Section. The commissioner shall require each applicant to submit a full set of fingerprints in order for the commissioner to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(1) The commissioner may contract for the collection, transmission, and resubmission of fingerprints required under this Section. If the commissioner elects to enter into a contract, the fee for collecting, transmitting, and retaining fingerprints shall be payable directly to the contractor by the applicant.

(2) The commissioner may receive criminal history record information from sources other than the Louisiana Bureau of Criminal Identification and Information.

D. The commissioner 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.

E. The commissioner may issue a commission authorizing the deputy commissioner of insurance fraud or any compliance investigator who is certified by the Council on Peace Officer Standards and Training (P.O.S.T.), or who may be qualified by the P.O.S.T. Council, to carry and use firearms in performance of their duties in investigating suspected administrative or civil insurance fraud. These powers and privileges shall not include arrest powers. The commissioner shall also provide appropriate credentials and badges of authority.

Renumbered from R.S. 22:1241.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1994, 3rd Ex.Sess., No. 50, § 2. Amended by Acts 2004, No. 826, § 1; Acts 2013, No. 217, § 1; Acts 2015, No. 162, § 1, eff. June 23, 2015.

§ 1923. Definitions

As used in this Part, the following terms shall have the meanings indicated in this Section:

(1) "Claim" shall mean any request or demand for payment or benefit, whether paid or not, made by a person either in writing or filed electronically.

(2) "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, producer, 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. 22:1791.

(g) Solicits or accepts new or renewal insurance risks by or for an unauthorized insurer, except as provided by Subpart O of Part I of Chapter 2 of this Title, R.S. 22:431 et seq., and Part III of this Chapter, R.S. 22:1941 et seq.

(h) Manufactures, sells, distributes, presents, or causes to be presented a fraudulent proof of insurance card or document.

(i) Alters a legitimate proof of insurance card or document.

(j) Presents, causes to be presented, or prepares with the knowledge or belief that it will be presented to a self-insured governmental entity any oral or written statement which he knows to contain materially false information as part of, in support of, denial of, or concerning any fact material to or conceals any information concerning any fact material to any claim for payment under such self-insured governmental entity's loss fund or risk pool. For the purposes of this Subparagraph, "self-insured governmental entity" shall mean any agency of the state, political subdivision of the state, or agency thereof, or consortium of governmental entities that maintains a self-insured loss fund or risk pool.

(k) Impersonates an insurance company, or a representative of an insurance company, without the authorization or consent of the insurance company for the purpose of executing a scheme or artifice to defraud a person.

(l) Impersonates another person or entity, whether real or fictitious, and purports himself to have the authority to direct healthcare treatment for the purpose of executing a scheme or artifice to defraud a person.

(m) Receives money or any other thing of value from any person, firm, or entity as a means of compensation for the acts of solicitation or criminal conspiracy done for the purpose of executing a scheme or artifice to defraud a person.

(3) "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.

Renumbered from R.S. 22:1242 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 1993, No. 663, § 2, eff. June 16, 1993; Acts 2004, No. 498, § 1; Acts 2008, No. 15, § 1; Acts 2011, No. 8, § 1, eff. June 7, 2011; Acts 2012, No. 271, § 1; Acts 2012, No. 862, § 1; Acts 2014, No. 116, § 1.

§ 1924. Prohibited activities and sanctions

A. (1) 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 commits any of the acts specified in Paragraph (2) or (3) of this Subsection 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 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. However, if the benefit pursued does not exceed one thousand dollars, the term of imprisonment shall not exceed six months, or the fine shall not exceed one thousand dollars, or both, on each count.

(2) The following acts shall be punishable as provided in Paragraph (1) of this Subsection:

(a) Committing any fraudulent insurance act as defined in R.S. 22:1923.

(b) Presenting or causing 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 or insurance policy.

(c) Assisting, abetting, soliciting, or conspiring with another to prepare or make any written or oral statement that is intended to be presented to any insurance company, insured, the Department of Insurance, 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 or insurance policy.

(3)(a) Knowingly and willfully committing health care fraud shall be punishable as provided in Paragraph (1) of this Subsection.

(b) "Health care fraud" shall mean, in conjunction with the delivery of or payment for health care benefits, items, or services:

(i) To execute a scheme or artifice to defraud any health care benefit program.

(ii) To obtain, by means of fraudulent claims, or false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

(c) For the purposes of this Paragraph, "knowingly and willfully" shall mean to continue with a practice, after written notice to cease such practice from a health care benefit program by certified mail, return receipt requested, except when the health care provider reasonably believes that such practice materially complies with coding or billing standards as issued by the American Medical Association, the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services, or the Louisiana Medicaid Program.

B. The criminal provisions of this Section shall be investigated, enforced, or prosecuted only by the proper law enforcement and prosecutorial agencies.

Renumbered from R.S. 22:1243 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 2001, No. 1158, § 1; Acts 2008, No. 15, § 1; Acts 2010, No. 632, § 1.

§ 1925. Automobile insurance policies

A. (1) Any person who with an intent to injure, defraud, or deceive any insurance company commits any of the acts specified in Paragraph (2) of this Subsection 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 were 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. However, mere possession of a fraudulent proof of insurance card or document shall be punishable by a fine of five hundred dollars, imprisonment for not more than six months, or both.

(2) The following acts shall be punishable as provided in Paragraph (1) of this Subsection:

(a) Knowingly causing or participating in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

(b) Knowingly presenting or causing 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.

(c) Engaging in any of the actions or activities described in R.S. 22:1924, relative to insurance policies in general.

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.

Renumbered from R.S. 22:1244 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 2005, No. 450, § 1; Acts 2008, No. 15, § 1.

§ 1926. 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 producers and adjusters, that suspects that a fraudulent insurance act will be, is being, or has been committed shall, within sixty days of the receipt of such notice, send to the division of insurance fraud, on a form prescribed by the commissioner, the information requested and such additional information relative to the insurance act and the

parties claiming loss or damages because of an occurrence or accident as the commissioner may require. The division of insurance fraud shall review such reports and select such insurance acts as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such insurance act 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 insurance act.

B. The division 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.

Renumbered from R.S. 22:1245 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 1999, No. 1312, § 2, eff. Jan. 1, 2000; Acts 2001, No. 598, § 1; Acts 2012, No. 201, § 1; Acts 2012, No. 271, § 1; Acts 2013, No. 217, § 1.

§ 1927. Materials and evidence

A. If matter that the division seeks to obtain by request is located outside the state, the person so requested may make it available to the division or its representative to examine at the place where it is located. The division 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 division'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 commissioner deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to be in the public domain. 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 commissioner, unless the commissioner consents, or until after notice to the commissioner and a hearing, a court of competent jurisdiction determines the division would not be necessarily hindered by such subpoena. Division personnel 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.

Renumbered from R.S. 22:1246 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 2012, No. 271, § 1; Acts 2013, No. 217, § 1.

§ 1928. 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 division 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 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.

Renumbered from R.S. 22:1247 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 707, § 2. Amended by Acts 2001, No. 1158, § 2; Acts 2012, No. 271, § 1; Acts 2013, No. 217, § 1.

§ 1929. 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 division of insurance fraud of the Department of Insurance shall be confidential and shall not be disclosed to others outside of the division of insurance fraud 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.

Renumbered from R.S. 22:1247.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1994, 3rd Ex.Sess., No. 50, § 2. Amended by Acts 2013, No. 217, § 1.

PART II-A. SLEDGE JEANSONNE LOUISIANA INSURANCE FRAUD PREVENTION ACT

§ 1931. Legislative findings; short title

A. The legislature finds that to protect the health, safety, and welfare of the citizens of this state, the attorney general of Louisiana and his assistants shall be agents of this state with the ability, authority, and resources to pursue civil monetary penalties, liquidated damages, or other remedies to protect the integrity of the insurance industry from persons who engage in fraud, misrepresentation, abuse, or other illegal practices, as further provided in this

Part, in order to obtain payments to which these insurance providers or persons are not entitled.

B. On June 7, 2011, Kim Sledge and Rhett Jeansonne were murdered while performing their duties as insurance fraud investigators for the Louisiana Department of Insurance. The tragedy of their loss is profound to their families, coworkers, and the citizens of this state they honorably served.

C. This Part shall be known and may be cited as the "Sledge Jeansonne Louisiana Insurance Fraud Prevention Act".

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.1. Definitions

As used in this Part the following terms shall have the following meanings unless a different meaning is clearly required by context:

(1) "Agent" means a person who is employed by or has a contractual relationship with another person or who acts on behalf of that person.

(2) "Attorney general" means the attorney general for the state of Louisiana.

(3) "Department" means the Department of Insurance.

(4) "Insurer" means any person or other entity authorized to transact and transacting insurance business in this state. Notwithstanding any contrary provisions of R.S. 22:242(7) or any other law, regulation, or definition contained in this Code, a health maintenance organization shall be deemed an insurer for purposes of this Part.

(5) "Knowing" or "knowingly" means that the person has actual knowledge of the falsity of the information or that the person acts in deliberate ignorance or reckless disregard of the truth or falsity of the information.

(6) "Order" means a final order imposed pursuant to a civil or criminal adjudication.

(7) "Person" means any natural or juridical entity or agent thereof as defined in federal or state law furnishing or claiming to furnish a good, service, or supply who is compensated with insurance proceeds.

(8) "P.O.S.T.-certified" means peace officer standards and training certified as established by the Louisiana Peace Officer Standards and Training Council.

(9) "Property" means any and all property, movable and immovable, corporeal and incorporeal.

(10) "Recovery" means the recovery of attempted benefits pursued, overpayments,

damages, fines, penalties, costs, expenses, restitution, attorney fees, interest, or settlement amounts.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.2. Prescription

A. No action brought pursuant to this Part shall be instituted later than ten years after the date upon which the alleged violation occurred. For violations involving a scheme or course of conduct, no action pursuant to this Part shall be instituted more than ten years after the latest component of the scheme or course of conduct occurred.

B. To the extent that the conduct giving rise to the cause of action involves the provision of services, supplies, merchandise, or benefits of a medical assistance program administered by the Department of Health and Hospitals, including any medical assistance programs administered by the state pursuant to 42 U.S.C. 1396 et seq., the provisions of this Part shall not apply.

C. An action by a prevailing defendant to recover costs, expenses, fees, and attorney fees pursuant to R.S. 22:1931.3 may be brought no later than sixty days after the rendering of a final nonappealable judgment. In the instance of a state criminal action, the action for recovery of the civil monetary penalty shall be brought within one year of the date of the criminal conviction, final plea, or pre-trial diversion agreement.

D. (1) In the case of a civil judgment rendered in federal court, the action for recovery of the civil monetary penalty pursuant to R.S. 22:1931.6 may be brought after the judgment becomes enforceable and no later than one year after written notification to the attorney general of the enforceable judgment.

(2) In the case of a criminal conviction, final plea, or pre-trial diversion agreement in federal court, the action for recovery pursuant to this Part may be brought after the conviction or plea is final and no later than one year after written notification to the attorney general of the rendering of the conviction or final plea.

(3) Any action for recovery brought pursuant to the provisions of this Part shall be filed in the Nineteenth Judicial District Court for the parish of East Baton Rouge.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.3. Civil actions authorized

A. No person shall knowingly commit any fraudulent insurance act as defined in R.S. 22:1923 or violate any provision of R.S. 22:1924.

B. The attorney general may institute a civil action in the Nineteenth Judicial District Court for the parish of East Baton Rouge to seek recovery from any person or persons who violate any provision of R.S. 22:1924. Each violation may be treated as a separate violation or may be combined into one violation at the option of the attorney general.

C. An action by a prevailing defendant to recover costs, expenses, fees, and attorney fees shall be ancillary to and shall be brought and heard in the same court as the civil action brought pursuant to the provisions of Subsection B of this Section.

D. A prevailing defendant may seek recovery only for costs, expenses, fees, and attorney fees if the court finds, following a contradictory hearing, that either of the following applies:

(1) The action was instituted by the attorney general pursuant to Subsection A of this Section after it should have been determined by the attorney general to be frivolous, vexatious, or brought primarily for the purpose of harassment.

(2) The attorney general proceeded with an action properly instituted pursuant to Subsection A of this Section after it should have been determined by the attorney general that proceeding would be frivolous, vexatious, or for the purpose of harassment.

E. Any action brought pursuant to the provisions of this Part shall be filed in the Nineteenth Judicial District Court for the parish of East Baton Rouge.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.4. Burden of proof; prima facie evidence; standard of review

A. The burden of proof in an action instituted pursuant to this Part shall be a preponderance of the evidence.

B. Proof by a preponderance of the evidence of a violation of R.S. 22:1924 shall be deemed to exist if the defendant has pled guilty or been convicted in any federal or state court when such charge arises out of circumstances which would be a violation of R.S. 22:1924.

C. The submission of a certified or true copy of a conviction shall be prima facie evidence of the same. The submission of the bill of information or of the indictment and the minutes of the court shall be prima facie evidence as to the circumstances underlying a criminal conviction or final plea.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.5. Civil monetary penalty

In a civil action instituted in the Nineteenth Judicial District Court for the parish of East Baton Rouge pursuant to the provisions of this Part, the attorney general may seek a civil monetary penalty provided in R.S. 22:1931.6 from any of the following:

(1) Any person determined by a court of competent jurisdiction to have violated any provision of R.S. 22:1924.

(2) Any person who has violated a settlement agreement entered into pursuant to this Part.

(3) A person who has been found liable in a civil action filed in federal court pursuant to 18 U.S.C. 1347 et seq., or 42 U.S.C. 1320a-7(a) or (b), et seq., or 31 U.S.C. 3729.

(4) A person who has entered a plea of guilty or nolo contendere to or has participated in a pre-trial diversion program for, or has been convicted in federal or state courts of criminal conduct arising out of circumstances which would constitute a violation of R.S. 22:1924.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.6. Recovery

A. (1) Actual damages incurred as a result of a violation of the provisions of this Part shall be recovered only once by the insurer and shall not be waived by the court.

(2) Except as provided in Paragraph (3) of this Subsection, actual damages shall equal the difference between the amount the insurer paid or would have paid and the amount that would have been due had not a violation of this Part occurred, plus interest at the maximum rate of judicial interest provided by R.S. 13:4202, from the date the damage occurred to the date of repayment. Actual damages shall include investigative expenses incurred by the insurer.

(3) If the violator is a managed care healthcare provider contracted with a health insurer, actual damages shall be determined in accordance with the violator's provider agreement.

B. Any person who is found to have violated R.S. 22:1924 shall be subject to a civil fine in an amount not to exceed ten thousand dollars per violation.

C. In addition to the actual damages provided in Subsection A of this Section and any civil fine imposed pursuant to Subsection B of this Section, a civil monetary penalty shall be imposed on the violator in an amount which equals three times the benefit pursued, including actual damages as a result of the violation.

D. (1) Any person who is found to have violated this Part shall be liable for all costs, expenses, and fees related to investigations and proceedings associated with the violation, including attorney fees.

(2) All awards of costs, expenses, fees, and attorney fees are subject to review by the appellate court for abuse of discretion.

(3) The attorney general shall promptly remit awards recovered for those costs, expenses, and fees incurred by the parties involved in the investigations or proceedings to the appropriate party.

E. (1) Payment of interest on the amount of the civil fine imposed pursuant to Subsection B of this Section shall be at the maximum rate of legal interest provided by R.S. 13:4202 from the date the damage occurred to the date of repayment.

(2) Prior to the imposition of a civil monetary penalty, the court may consider whether extenuating circumstances exist as provided in R.S. 22:1931.7.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.7. Waiver; extenuating circumstances

If a waiver is requested by the attorney general, the court may waive any recovery, except for actual damages, required to be imposed pursuant to the provisions of this Part provided all of the following extenuating circumstances are found to be applicable:

(1) The violator furnished all the information known to him about the specific allegation to the department or attorney general no later than thirty days after the violator first obtained the information.

(2) The violator cooperated fully with all federal or state investigations concerning the specific allegation.

(3) At the time the violator furnished the information concerning the specific allegation to the department or the attorney general, no criminal, civil, or departmental investigation or proceeding had been commenced as to the alleged violation.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.8. Deposit of monies collected

All monies collected pursuant to this Part shall be dedicated to and deposited into the Insurance Fraud Investigation Fund pursuant to R.S. 40:1428(C). Forty percent of the monies deposited into the fund pursuant to this Part shall be allocated from the fund to the attorney general's office for purposes as provided by law.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.9. Assessment reduction or recalculation

Except as provided in this Part, there shall be no reduction or recalculation in the Insurance Fraud Investigation Fund assessment allocation to the attorney general's office as provided in R.S. 40:1428.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.10. Civil investigative demand

A. If the attorney general has information, evidence, or reason to believe that any person or entity may be in possession, custody, or control of any documentary material or information relevant to an investigation for a possible violation of this Part, he or any of his assistants may issue to the person or entity a civil investigative demand before the commencement of a civil proceeding to require the production of the documentary material for inspection or copying or reproduction, or the answering under oath and in writing of interrogatories. Any civil investigative demand issued pursuant to this Part shall state a general description of the subject matter being investigated and the applicable provisions of law constituting the alleged violation of this Part. A civil investigative demand for the production of documentary material shall describe each class of documentary material to be produced with such definiteness and certainty as to permit such material to be fairly identified. A civil investigative demand for answers to written interrogatories shall set forth with specificity the written interrogatories to be answered. Each investigative demand shall set a return date of no earlier than twenty days after service of the demand upon the person or his representative or agent.

B. A civil investigative demand issued pursuant to this Part may be served by the sheriff or a P.O.S.T.-certified investigator employed by the attorney general

or by the office of state police when the demand is issued to a resident or a domestic business entity found in this state. A civil investigative demand issued to a non-resident or a foreign business entity may be served using long-arm jurisdiction as provided for in the Code of Civil Procedure.

C. Upon failure to comply with the civil investigative demand, the attorney general may apply to the district court having jurisdiction over the person to compel compliance with the civil investigative demand.

D. Except as otherwise provided in this Section, no documentary material, answers to interrogatories, or copies thereof, while in the possession of the attorney general or any other agency assisting the attorney general with the matter under investigation, shall be available for examination by any person or entity except as determined by the attorney general and subject to any conditions imposed by him for effective enforcement of the laws of this state. Nothing in this Section shall be construed to prohibit or limit the attorney general from sharing any documentary material, answers to interrogatories, or copies thereof with the United States government, any other state government, any federal or state agency, or any person or entity that may be assisting in the investigation or prosecution of the subject matter of the civil investigative demand.

E. The attorney general may use documentary material derived from information obtained pursuant to this Section, or copies of that material, as the attorney general determines necessary for the enforcement of the laws of this state, including presentation before a court.

F. If any documentary material has been produced by any person or entity in the course of any investigation pursuant to a civil investigative demand and any case or proceeding before the court or grand jury arising out of such investigation, or any proceeding before any state agency involving such material has been completed, or if no case or proceeding in which such material may be used has been commenced within a reasonable time after analysis of all documentary material and other information assembled in the course of the investigation, the attorney general, upon written request of the person or entity who produced the material, shall return to such person or entity any such material that has not passed into the control of any court, grand jury, or agency through introduction into the record of such case or proceeding.

G. "Documentary material" as used in this Section shall include but is not limited to all electronically-stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations that would be subject to a request for production under Federal Rule of Civil Procedure 34 as it exists now or is hereafter amended.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.11. Investigative deposition

A. When the attorney general has information, evidence, or reason to believe that

a violation of this Part has occurred, the attorney general may issue an investigative subpoena for deposition testimony to any person or entity that may have information or knowledge relevant to the matter under investigation, or for the purpose of revealing, identifying, or explaining documentary material or other physical evidence sought under R.S. 22:1931.10. The investigative subpoena shall contain a general description of the matter under investigation and a notice informing the prospective deponent of his right to counsel at the deposition with opportunity for cross-examination. The deposition shall be conducted at the principal place of business of the deponent, at his place of residence, at his domicile, or, if agreeable to the deponent, at some other place convenient to the attorney general and the lawful and designated attorney representative of the deponent. The deposition shall be held at a date no earlier than seven days after the date on which demand is received, unless the attorney general or an assistant attorney general designated by the attorney general determines that exceptional circumstances are present which warrant the commencement of such testimony within a lesser period of time.

B. An investigative subpoena issued pursuant to this Part may be served by the sheriff or a P.O.S.T.-certified investigator employed by the attorney general or by the office of state police when the demand is issued to a resident or a domestic business entity of this state. An investigative subpoena issued to a non-resident or a foreign business entity may be served using long-arm jurisdiction as provided for in the Code of Civil Procedure.

C. When the investigative subpoena is issued to a business entity, the entity shall designate one or more officers, directors, or managing agents, who are responsible for complying with the subpoena on the entity's behalf, and may set forth, for each person designated, the matters on which he will testify. The persons so designated shall testify as to matters known or reasonably available to the organization.

D. Upon failure of a person or entity to comply with the investigative subpoena, the attorney general may apply to the district court having jurisdiction over the person to compel compliance with the investigative subpoena. Failure to comply with a court order is punishable by contempt.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.12. Asset forfeiture

A. In accordance with the provisions of Subsection B of this Section, the court may order the forfeiture of property to satisfy recovery pursuant to this Part under either of the following circumstances:

(1) The court may order a person from whom recovery is due to forfeit property which constitutes or was derived directly or indirectly from gross proceeds traceable to the violation which forms the basis for the recovery.

(2) If the attorney general shows that property was transferred to a third party

to avoid paying recovery, or in an attempt to protect the property from forfeiture, the court may order the third party to forfeit the transferred property.

B. Prior to the forfeiture of property, a contradictory hearing shall be held during which the attorney general shall prove by clear and convincing evidence that the property in question is subject to forfeiture pursuant to Subsection A of this Section. No such contradictory hearing shall be required if the owner of the property in question agrees to the forfeiture.

C. If property is transferred to another person within six months prior to the occurrence or after the occurrence of the violation for which recovery is due or within six months prior to or after the institution of a criminal, civil, or departmental investigation or proceeding, it shall be prima facie evidence that the transfer was intended to avoid paying recovery or was an attempt to protect the property from forfeiture.

D. The healthcare provider or other person from whom recovery is due shall have an affirmative duty to fully disclose all property and liabilities and all transfers of property which meet the criteria of Subsection C of this Section to the court and the attorney general.

Added by Acts 2012, No. 862, § 1.

Termination of Part

This Part II-A shall terminate by its own terms on August 1, 2016. See R.S. 22:1931.13.

§ 1931.13. Termination of Part

This Part shall terminate on August 1, 2016.

Added by Acts 2012, No. 862, § 1. Amended by Acts 2014, No. 129, § 1, eff. Aug. 1, 2014.

Termination of Part

This Part II-A shall terminate by the terms of this section on August 1, 2016.

PART III. UNAUTHORIZED INSURERS—FALSE ADVERTISING PROCESS LAW

§ 1941. 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 provides in this Part 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 in this Part to be in addition to any existing powers of this state.

Renumbered from R.S. 22:1231 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 174, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1942. Definitions

When used in this Part:

(1) "Commissioner" shall mean the commissioner of insurance of this state.

(2) "Residents" shall mean and include persons, partnerships, or corporations, domestic, alien, or foreign.

(3) "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 IV of this Chapter, R.S. 22:1961.

Renumbered from R.S. 22:1232 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 174, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1943. Misrepresentations by foreign insurer, notice to domiciliary supervisory official

No unauthorized foreign or alien insurer of the kind described in R.S. 22:1941 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.

Renumbered from R.S. 22:1233 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 174, § 1.

§ 1944. Action by commissioner

If, after thirty days following the giving of the notice mentioned in R.S. 22:1943, such insurer has failed to cease making, issuing, or circulating such 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. 22:1945, he shall take action against such insurer under the Unfair Trade Practice Law.

Renumbered from R.S. 22:1234 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 174, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1945. Service upon unauthorized insurer

A. (1) Any of the following acts in this state, effected by mail or otherwise, by any such unauthorized foreign or alien insurer 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:

(a) The issuance or delivery of contracts or insurance to residents of this state.

(b) The solicitation of applications for such contracts.

(c) The collection of premiums, membership fees, assessments, or other considerations for such contracts.

(d) Any other transaction of insurance business.

(2) The secretary of state may be served with all statements of charges, notices, and lawful process in any proceeding instituted in respect to the misrepresentations set forth in R.S. 22:1943 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 the 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 such 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 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 if 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 compliance with this Section 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. (1) 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 as provided in Paragraph (2) of this Subsection upon any person within this state who on behalf of such insurer is doing any of the following:

(a) Soliciting insurance.

(b) Making, issuing, or delivering any contract of insurance.

(c) Collecting or receiving in this state any premium for insurance.

(2) A copy of such statement of charges, notices, or process shall be 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 compliance with this Section shall be 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 permitted by law.

Renumbered from R.S. 22:1235 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 174, § 1. Amended by Acts 2012, No. 271, § 1.

§ 1946. Advertisement by insurers

A. 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.

B. 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.

C. Whoever violates this Section shall be fined not more than one thousand dollars or imprisoned for not more than one year, or both.

Renumbered from R.S. 22:1523 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

PART IV. UNFAIR TRADE PRACTICES

§ 1961. 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,[1] 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.

Renumbered from R.S. 22:1211 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 953, § 1.

[1] 15 U.S.C.A. §§ 1011 to 1015.

§ 1962. 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 producers. 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 this Code as "insurance agent", "agent", "insurance broker", "broker", "insurance solicitor", "solicitor", or "surplus lines broker".

Renumbered from R.S. 22:1212 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 953, § 1; Acts 1997, No. 949, § 1; Acts 2001, No. 158, § 1, eff. Jan. 1, 2002; Acts 2012, No. 271, § 1.

§ 1963. 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. 22:1902 et seq.

Renumbered from R.S. 22:1213 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 953, § 1.

§ 1964. Methods, acts, and practices which are defined 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) Makes 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, if, 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 thereon, or in any of the terms or conditions of such contract, or in any other manner whatever, if, 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. 22:34.

(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 in this Paragraph 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 regard 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.

(8.1) Nothing in Paragraph (7) or (8) of this Subsection 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 producer or producers, company or companies, or type of company or types of companies. However this Paragraph 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. 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, group health, and any other employee benefit plan.

(11) No person, as defined in R.S. 22:46(12), 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 producers, 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, producer, 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: 1164 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 Item (a)(ii) of this Paragraph.

(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: 1164 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) of this Paragraph 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 and shall specifically state:

(aa) The services for which the fee is to be charged.

(bb) The amount of the fee to be charged or how it will be determined or calculated.

(cc) That the client is under no obligation to purchase any insurance product through the insurance producer 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 Subparagraph, 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) of this Paragraph, 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) of this Paragraph 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) of this Paragraph 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 a producer or offering any incentive for a producer who represents more than one company to limit information provided to consumers on limited benefit or supplemental benefit plans, including attempting to enforce a provision of a sales representative agreement, a sales agent agreement, a nonsolicitation agreement, or a noncompetition agreement against such a producer which would result in limiting the information that the producer provides to consumers on limited benefit or supplemental 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 producer and shall not be subject to the penalties provided for in R.S. 22:1969.

(25) Requiring a producer or offering any incentive for a producer who represents more than one insurance company to limit the number of other insurance companies such a producer may represent, including attempting to enforce a provision of a sales representative agreement, a sales agent agreement, a nonsolicitation agreement, or a noncompetition agreement against such a producer which would result in limiting the number of other insurance companies that the producer may represent. 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. 22:1969.

(26) Failure by an organization that negotiates with a pharmacy or pharmacies, or an organization that represents an independent pharmacy or a group of independent pharmacies, to provide to a pharmacy a contract, agreement, or other documentation relative to the pharmacy's network participation with a third-party payor as required in R.S. 22:1857.1.

(27) Deliberate use of misrepresentations or false statements for the purpose of convincing a customer to replace a limited benefit insurance policy. The commissioner shall promulgate regulations which address the replacement of limited benefit insurance policies as defined in R.S. 22:47(2)(c).

(28) Failure by an admitted insurer upon renewal or issuance of any policy or contract of insurance which includes a provision that the policy or contract contains defense costs within the limit of liability to provide notice of such provision through a separate notice or inclusion on the declaration page of the insurance policy or contract. Failure to comply with the provisions of this Paragraph shall not subject the insurer to the penalties provided in R.S. 22:1969.

Renumbered from R.S. 22:1214 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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, eff. July 2, 1999; Acts 2003, No. 129, § 1, eff. May 28, 2003; Acts 2004, No. 770, § 1; Acts 2012, No. 271, § 1; Acts 2014, No. 490, § 1; Acts 2014, No. 844, § 1.

§§ 1965, 1966. Repealed by Acts 2012, No. 78, § 1

§ 1967. Power of commissioner of insurance

The commissioner of insurance shall have power to examine and investigate the affairs of every person engaged in the business of insurance, including violations of R.S. 22:1902 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.

Renumbered from R.S. 22:1215 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 953, § 1; Acts 2012, No. 271, § 1.

§ 1968. 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 this Code, whether or not defined in this Part, the commissioner shall issue a notice of wrongful conduct to said person in accordance and compliance with R.S. 49:961 describing the unfair trade practice and citing the law which is deemed by the commissioner to be violated.

Renumbered from R.S. 22:1216 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 953, § 1; Acts 2009, No. 317, § 1; Acts 2012, No. 271, § 1.

§ 1969. Violations, penalties

A. If, after receiving the person's answer or response or if no answer or response is received within twenty days of receipt of mailing, faxing, or delivery of the notice, 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.

B. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1217 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1966, No. 179, § 1; Acts 1989, No. 638, § 1; Acts 1993, No. 953, § 1; Acts 2009, No. 317, § 1.

§ 1970. Cease and desist order; penalty for violation

A. Any person who violates a cease and desist order of the commissioner under R.S. 22:1969 and while such order is in effect may after compliance with R.S. 49:961 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 such person's license or certificate of authority.

B. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1217.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 638, § 1. Amended by Acts 1993, No. 953, § 1; Acts 2009, No. 317, § 1.

§ 1971. 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 in this Section is intended to abrogate or modify in any way or form any statutory privilege or immunity enjoyed by any person.

Renumbered from R.S. 22:1218 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1986, No. 744, § 1. Amended by Acts 1993, No. 953, § 1; Acts 2012, No. 271, § 1.

§ 1972. 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.

Renumbered from R.S. 22:1219 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 638, § 1. Amended by Acts 1992, No. 377, § 1, eff. June 17, 1992; Acts 1993, No. 953, § 1.

§ 1973. 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 of this Section:

(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.

(6) Failing to pay claims pursuant to R.S. 22:1893 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. 22:2051 et seq., shall not be liable for any special damages awarded under the provisions of this Section.

Renumbered from R.S. 22:1220 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 308, § 1, eff. July 6, 1990. Amended by Acts 2006, 1st Ex.Sess., No. 12, § 1, eff. Feb. 23, 2006; Acts 2012, No. 271, § 1.

CHAPTER 8. EXAMINATION AND INVESTIGATIONS

§ 1981. Commissioner of insurance to examine insurers and producers

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 Chapter 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 producer doing business in this state whenever he has received at least three complaints within a thirty-day period that the producer is not acting in conformance with this Code.

(3) For purposes of completing an examination of any company under this Chapter, and in addition to any other power granted to the commissioner by this Code, the commissioner may examine or investigate any person, as defined in R.S. 22:692(7)[1], 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 Chapter, 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. Such reports may be accepted only 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 Chapter 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 Chapter 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.

Renumbered from R.S. 22:1301 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2012, No. 271, § 1.

[1] R.S. 22:692 was repealed in 2012. See, now, R.S. 22:691.2.

§ 1982. Repealed by Acts 2010, No. 794, § 4

§ 1983. 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 Paragraph (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 either:

(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.

(2) Rejecting the examination report and ordering a hearing pursuant to the provisions of Chapter 12 of this Title, for purposes of obtaining additional documentation, data, information, and testimony.

F. All orders entered pursuant to Paragraph (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 he has 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 Chapter 12 of this Title.

H. The hearing provided for under Paragraph (E)(2) or Subsection G of this Section shall be a confidential proceeding. At the conclusion of the hearing, 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 Paragraph (C)(1) or (E)(1), or Subsection 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. 22:1981(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 this 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 Chapter.

(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 Chapter, 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. 22:1981(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 Chapter. 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 Chapter.

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 Chapter.

(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 Chapter, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

Renumbered from R.S. 22:1302 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1964, No. 137, § 1; Acts 1992, No. 811, § 1; Acts 2012, No. 271, § 1.

§ 1984. Commissioner of insurance to conduct financial and market analysis of insurers and regulated entities

A. In addition to those examinations performed by the commissioner of insurance pursuant to R.S. 22:1981, the commissioner of insurance shall conduct financial and market analysis review of all insurers authorized to do business in this state and may conduct regulatory reviews of entities regulated by this Title or the Department of Insurance except for trusts established and operated under R.S. 22:46(9)(b), (c), or (d). Such reviews may include the annual statement and the market conduct annual statement of the insurer or regulated entity 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. In lieu of conducting a financial or market analysis under this Section of any foreign or alien insurer licensed in this state, the commissioner may rely upon the financial or market analysis conducted by the insurance department for the company's state of domicile or port-of-entry state accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program.

C. Failure by an insurer or regulated entity to supply information requested by

the Department of Insurance during the course of financial or market analysis may subject the insurer or regulated entity to revocation or suspension of its license, or, in lieu thereof, a fine not to exceed ten thousand dollars per occurrence. Every insurer or regulated entity shall produce and make freely accessible to the commissioner of insurance the accounts, records, documents, and files in its possession or control.

D. All work papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner, or any other person in the course of conducting a regulatory review, financial, or market analysis, including market conduct annual statement information, performed under this Section, as well as the review and analysis of such information, shall be given confidential treatment and are not subject to subpoena or to discovery and may not be made public by the commissioner or any other person, except that access may be granted to the National Association of Insurance Commissioners, insurance department of other states, international, federal, or state law enforcement agencies or international, federal, or state regulatory agencies with statutory oversight over the financial services industry, if the recipient agrees to maintain the confidentiality of those documents which are confidential under the laws of this state. Any documents, materials, or other information which are disclosed by the commissioner to a third party shall not be admissible in evidence in a private civil action and shall be exempt from any applicable freedom of information law, public records law, or similar statute. No person or entity which receives or has access to documents, materials, or other information under this Section shall be permitted or required to testify in a private civil action concerning such documents, materials, or other information. No waiver of an applicable privilege or a claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the commissioner or to any other person granted access under this Section as a result of sharing such documents, materials, or other information as provided in this Section. Nothing in this Section shall require an insurer to disclose documents, materials, or other information to a third party that is not otherwise required by law to be disclosed.

E. In conducting financial or market analysis, the examiner or examiners shall observe those guidelines and procedures set forth in the *Financial Analysis Handbook* or *Market Regulation 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.

F. Nothing contained in this Chapter shall be construed to limit the commissioner's authority to use any final or preliminary analysis findings, any Department of Insurance or company work papers or other documents, or any other information discovered or developed during the course of any analysis in the furtherance of any legal or regulatory action which the commissioner may, in his sole discretion, deem appropriate.

G. Any insurer or regulated entity against whom a fine has been levied shall be given thirty days notice of such action. Upon receipt of this notice, the aggrieved insurer or regulated entity may apply for and shall be entitled to a hearing pursuant to R.S. 22:2191 et seq.

Renumbered from R.S. 22:1303 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1990, No. 259, § 1, eff. Dec. 31, 1991 as to all

included domestic insurers, and eff. Dec. 31, 1992 for all other included insurers; Acts 2010, No. 968, § 1; Acts 2012, No. 271, § 1.

§ 1985. Review and examination expense; how paid

A. Whenever the commissioner of insurance makes an examination or investigation pursuant to this Chapter, all expenses incurred by the commissioner of insurance in conducting such examination or investigation, 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 entity or person examined.

B. For all entities who are charged the annual financial regulation fee as provided in R.S. 22:821(B)(2), the charges for any financial examination shall be waived. The entity being examined may still be responsible for any travel-related expenses.

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.

Renumbered from R.S. 22:1304 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1990, No. 259, § 1, eff. Dec. 31, 1991 as to all included domestic insurers, and eff. Dec. 31, 1992 for all other included insurers; Acts 1997, No. 1449, § 1; Acts 2001, No. 488, § 1; Acts 2007, No. 191, § 1, eff. July 1, 2007.

§ 1986. Authority to employ examiners and other assistants

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.

Renumbered from R.S. 22:1305 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1991, No. 793, § 1. Amended by Acts 2012, No. 60, § 1.

§ 1987. 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 Chapter, 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 Chapter 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.

Renumbered from R.S. 22:1306 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125.

§ 1988. 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 in R.S. 22:1987, 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.

Renumbered from R.S. 22:1307 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 1989. 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. 22:809 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 the following:

(1) Any insurance producer, 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.

Renumbered from R.S. 22:1308 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 1990. 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.

Renumbered from R.S. 22:1309 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 1991. Power to examine under oath; subpoena witnesses

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.

Renumbered from R.S. 22:1310 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 1992. 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 in this Chapter for the examination of insurers.

Renumbered from R.S. 22:1311 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 1993. 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.

Renumbered from R.S. 22:1314 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 1994. 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 of its employees or administrators 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 of its employees or administrators the value of any asset or the amount of any liability of such insurer, or any associated affiliate, subsidiary, or holding company; however, 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 associated insurer, or affiliate, subsidiary, or holding company when such disclosure is properly requested or required in writing by an examiner or administrator of the Department of Insurance.

(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 its examiners and administrators.

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.

Renumbered from R.S. 22:1315 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1979, No. 118, § 1. Amended by Acts 1992, No. 1114, § 1; Acts 2012, No. 271, § 1.

§ 1995. 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 ten days' notice of such action. Upon receipt of this notice, the person aggrieved may apply for and shall be entitled to a hearing pursuant to Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1316 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 773, § 1. Amended by Acts 2009, No. 317, § 1.

CHAPTER 9. REHABILITATION, LIQUIDATION, CONSERVATION

§ 2001. Scope of Chapter

This Chapter shall apply to all insurers or persons purporting to be doing an insurance business in this state or in the process of organizing 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.

Renumbered from R.S. 22:732 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Renumbered from R.S. 22: by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1991, No. 997, § 1; Acts 1995, No. 595, § 1, eff. June 18, 1995; Acts 2012, No. 271, § 1.

§ 2002. Persons covered

The proceedings authorized by this Chapter 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 this Code.

(3) Any other specialty type insurer not covered by the general law which shall be subject to this Chapter.

(4) Producers, insurers, or any person or persons acting as an agent 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.

Renumbered from R.S. 22:732.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2. Amended by Acts 2012, No. 271, § 1.

§ 2003. Definitions

For the purposes of this Chapter:

(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 as an insurer under a license or certificate of authority issued by the Department of Insurance.

(f) Acting as a producer 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 Chapter 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 Chapter, 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 Chapter, any other persons included under R.S. 22:2002 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 Chapter.

(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.

Renumbered from R.S. 22:732.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2. Amended by Acts 2012, No. 271, § 1.

§ 2004. Venue

A. An action under this Chapter 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 Chapter 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.

Renumbered from R.S. 22:732.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 955, § 1. Amended by Acts 1997, No. 1298, § 1.

§ 2005. Grounds for rehabilitation and liquidation

The commissioner of insurance may apply by petition to the district court of the parish in which an 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 Chapter 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, whenever any domestic insurer is in one of the following positions:

(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.

(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.

(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.

(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.

(5) Is found to be in such condition that its further transaction of business would be hazardous to its policyholders, its creditors, or the public.

(6) Has an officer who has refused upon reasonable demand to be examined under oath touching its affairs.

(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. 22:81, and except as to the amount of the surplus required by this Code to be maintained.

(8) Has ceased for the period of one year to transact insurance business.

(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.

(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.

(11) Consents to such an order by a majority of its directors, stockholders, or members.

(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.

(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.

(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.

(15) Has failed to file its annual report or other financial report required by R.S. 22:571 within the time allowed by law and, within ten days of receipt of written demand by the commissioner, has failed to provide the report.

(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.

Renumbered from R.S. 22:733 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 1992, No. 808, § 1, eff. July 7, 1992; Acts 1992, No. 1095, § 2; Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1; Acts 2012, No. 468, § 1.

§ 2005.1. Compliance with certain federal provisions

A. The provisions of this Section apply in accordance with Title II of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub.L. 111-203 with respect to each insurance company that is a covered financial company, or a subsidiary or affiliate of a covered financial company, as defined under 12 U.S.C. 5381.

B. The commissioner of insurance may file a petition for an order of rehabilitation or liquidation pursuant to this Section on any of the following grounds:

(1) Upon determination and notification given by the Secretary of the Treasury of the United States in consultation with the president of the United States that the insurance company is a financial company satisfying the requirements of 12 U.S.C. 5383(b), and the board of directors, or any body performing similar functions, of the insurance company acquiesces or consents to the appointment of a receiver pursuant to 12 U.S.C. 5382(a)(1)(A)(i), with such consent to be considered as consent to an order of rehabilitation or liquidation.

(2) Upon an order of the United States District Court for the District of Columbia under 12 U.S.C. 5382(a)(1)(A)(iv)(I) granting the petition of the Secretary of the Treasury of the United States concerning the insurance company under 12 U.S.C. 5382(a)(1)(A)(i).

(3) A petition by the Secretary of the Treasury of the United States concerning the insurance company is granted by operation of law under 12 U.S.C. 5382(a)(1)(A)(v).

C. Notwithstanding any other provision of law to the contrary, after notice to the insurance company, the receivership court may grant an order on the petition of the commissioner for rehabilitation or liquidation within twenty-four hours after the filing of the petition pursuant to this Section.

D. If the receivership court does not make a determination on a petition for rehabilitation or liquidation filed by the commissioner pursuant to this Section within twenty-four hours after its filing, then the petition shall be deemed granted by operation of law upon the expiration of the twenty-four hour period. At the time that an order is deemed granted pursuant to this Section, the provisions of this Chapter shall be deemed to be in effect, and the commissioner or his designee shall be deemed to be affirmed as receiver and have all of the applicable powers provided by this Code, regardless of whether an order has been entered. The receivership court shall, within ten days, enter an order of rehabilitation or liquidation that does both of the following:

(1) Becomes effective as of the date that it is deemed granted by operation of law.

(2) Conforms to provisions for rehabilitation or liquidation contained in this Chapter, as applicable.

E. The court may hold a hearing within ten days after granting of such an order of liquidation or rehabilitation pursuant to this Section at which hearing the court may sustain or revoke the order of rehabilitation or liquidation or grant such other relief as the nature of the case and the interest of the insurer's policyholders, creditors, or the public may require.

F. Any order of rehabilitation or liquidation granted pursuant to this Section or any part thereof shall not be subject to any stay or injunction pending appeal.

G. Nothing in this Section shall be construed to supersede or impair any other power or authority of the commissioner or the court under this Code.

H. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the department or its employees, or the commissioner or his designee in his capacity as receiver, rehabilitator, liquidator, or conservator, or otherwise, or a special deputy, or the receiver's assistants or the receiver's contractors for any action taken by them in the performance of their powers and duties pursuant to this Section or their duties under this Chapter.

Added by Acts 2012, No. 468, § 1.

§ 2006. 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 provided in this Chapter 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.

Renumbered from R.S. 22:734 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1992, No. 808, § 1, eff. July 7, 1992; Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1.

§ 2007. 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 Chapter 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 Chapter 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.

Renumbered from R.S. 22:734.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2.

§ 2008. Order of rehabilitation or liquidation

A. 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 and peremption 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 and peremption 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.

Renumbered from R.S. 22:735 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1; Acts 2012, No. 468, § 1.

§ 2009. 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, including producers, 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 or rehabilitation order to transfer policy obligations to a solvent assuming insurer.

(4) To enter into such agreements or contracts as 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.

Renumbered from R.S. 22:736 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1992, No. 1095, § 2; Acts 2012, No. 271, § 1; Acts 2012, No. 468, § 1.

§ 2010. 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 Chapter.

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 such 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 such parties in interest, and if the 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 such parties has been obtained and that it is best for the interests of parties that such contract be entered into, the court shall by written order approve the acts of the commissioner of insurance and authorize him to execute such 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.

Renumbered from R.S. 22:737 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 171, § 1; Acts 1991, No. 742, § 1; Acts 2012, No. 271, § 1.

§ 2011. 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. 22:2006 or issued an order directing rehabilitation or liquidation under R.S. 22:2008, 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. 22:2006, 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. 22:2008, any and all premiums due the insurer shall be paid to the commissioner of insurance until termination, under the provisions of R.S. 22:2008, 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. 22:2008, 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. 22:2010(D).

E. Upon issuance of an injunction under R.S. 22:2006 or an order of rehabilitation or liquidation under R.S. 22:2008, 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.

Renumbered from R.S. 22:737.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1989, No. 697, § 1. Amended by Acts 1992, No. 1095, § 1.

§ 2012. Unearned premium; limitation of claims by insolvent insurers

A. Any claim of an insolvent insurer against an insured or against the producer 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 producer, 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 producer is entitled to retain the commission due on earned premiums. The insured is entitled to any unearned premium which the producer 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.

Renumbered from R.S. 22:737.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2001, No. 158, § 1, eff. Jan. 1, 2002. Amended by Acts 2012, No. 271, § 1.

§ 2013. 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, however, 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.

Renumbered from R.S. 22:738 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1.

§ 2014. Deposit of monies collected

The monies collected by the commissioner of insurance in a proceeding under this Chapter 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.

Renumbered from R.S. 22:739 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 1982, No. 748, § 1; Acts 1991, No. 738, § 1.

§ 2015. Investment in securities

Notwithstanding any law to the contrary, the commissioner of insurance may invest any monies held in any proceedings under this Chapter 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.

Renumbered from R.S. 22:739.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 783, § 1.

§ 2016. Borrowing on the pledge of assets

For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution provided for by this Chapter 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 Chapter. 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.

Renumbered from R.S. 22:740 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2017. 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 Chapter, 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.

Renumbered from R.S. 22:742 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1992, No. 808, § 1, eff. July 7, 1992; Acts 1993, No. 955, § 1.

§ 2018. Appointment of assistants

A. For the purpose of this Chapter, 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, attorneys, or assistants he deems 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, attorney, 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 commissioner of insurance may employ staff counsel of the Department of Insurance or special counsel to provide representation in all matters covered pursuant to this Chapter in which the assets of an insurer's estate are less than one million dollars. The fees and expenses of staff or special counsel employed pursuant to this Subsection may be reimbursed pursuant to Subsection A of this Section.

C. The attorney general shall provide representation for the commissioner of insurance in all matters covered pursuant to this Chapter in which the assets of an insurer's estate equal or exceed one million dollars. The attorney general may appoint special counsel to provide this representation. The attorney general shall submit to the receivership court a certification of expenses and legal fees for staff and special counsel for reimbursement pursuant to Subsection A of this Section.

D. The commissioner of insurance shall name and select the special counsel employed pursuant to this Section subject to the approval of the attorney general, who shall not unreasonably withhold such approval.

Renumbered from R.S. 22:743 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1979, No. 116, § 1, eff. June 29, 1979; Acts 1991, No. 382, § 1, eff. July 6, 1991; Acts 2012, No. 271, § 1; Acts 2015, No. 340, § 1, eff. June 29, 2015.

Retroactive Application—Acts 2015, No. 340

Section 2 of Acts 2015, No. 340 provides:

"The provisions of Section 1 of this Act shall have retroactive application to all pending receivership proceedings."

§ 2019. 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 pursuant to this Chapter, nor for services rendered by any public officer for serving any process; however, 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.

Renumbered from R.S. 22:744 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2020. 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 Chapter, 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 pursuant to this Chapter, shall knowingly participate in the making of any transfer or the creation of any lien prohibited by Subsection A of this Section 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 Subsection B of this Section, 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.

Renumbered from R.S. 22:745 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2021. 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 pursuant to this Chapter 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 pursuant to this Chapter, which is fraudulent pursuant to 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 less than fair consideration 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. 22:2023(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.

Renumbered from R.S. 22:745.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2. Amended by Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1.

§ 2022. 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 Chapter shall impair the negotiability of currency or

negotiable instruments.

Renumbered from R.S. 22:745.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2. Amended by Acts 1993, No. 955, § 1.

§ 2023. 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 Chapter, 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 of this Section 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. 22:2023(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 Chapter 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 Chapter, 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. 22:2023(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.

Renumbered from R.S. 22:745.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2. Amended by Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1.

§ 2024. 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 Chapter 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.

Renumbered from R.S. 22:745.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1095, § 2.

§ 2025. 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. 22:2061(B) and 2093(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. 22:2061(B), 2055(3), 2083, and 2093(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 pursuant to this Chapter, 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 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) of this Section. 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.

Renumbered from R.S. 22:746 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1981, No. 412, § 1; Acts 1995, No. 1210, § 1, eff. June 29, 1995; Acts 2012, No. 271, § 1.

§ 2026. Set-offs

A. In all cases of mutual debts or mutual credits between the insurer and another person, such credits and debts shall be set-off and only the balance shall be allowed or paid; however, no set-off shall be allowed in favor of any person when either of the following apply:

(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.

(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.

B. When a producer 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.

Renumbered from R.S. 22:747 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 172, § 1; Acts 2012, No. 271, § 1.

§ 2027. Time to file claims

A. If upon the granting of an order of liquidation under this Chapter 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 such date, have been paid in full with interest.

Renumbered from R.S. 22:748 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2028. 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 such 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 such list.

C. No contingent claim other than claims of the character described in Subsection D of this Section 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. 22:2027 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. 22:2027 had been made.

D. (1) When an insurer has been adjudicated to be insolvent by an order made pursuant to R.S. 22:2027, 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 Chapter 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 letter addressed to the last known address of the claimant, allowing ten days after receipt of said notice in which to file objections to the action of the receiver. The objections shall be filed with the receiver and in the receivership court and 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 Chapter 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 Chapter, 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 Chapter 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 such 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. 22:2020 or to whom conveyances or transfers, assignments or encumbrances have been made or given which are void under R.S. 22:2020, shall not be allowed unless such creditors or policyholders shall surrender such preferences, conveyances, transfers, assignments or encumbrances.

Renumbered from R.S. 22:749 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 173, § 1; Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1; Acts 2012, No. 468, § 1.

§ 2029. 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 each of the following:

(1) The reasonable value of the assets of the insurer.

(2) The insurer's probable liabilities.

(3) The probable necessary assessments, if any, to pay all claims and expenses in full, including expenses of administration.

Renumbered from R.S. 22:750 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2030. 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.

Renumbered from R.S. 22:751 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2031. Order to pay assessment

After levy of assessment as provided in R.S. 22:2030, 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. 22:2033 and why the commissioner of insurance should not have judgment therefor.

Renumbered from R.S. 22:752 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2032. 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 both:

(1) Published in such manner as shall be directed by the court.

(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. 22:2031.

Renumbered from R.S. 22:753 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2033. Judgment upon the assessment

A. On the return day of the order to show cause provided for in R.S. 22:2031 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 negating 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.

Renumbered from R.S. 22:754 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2034. 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. 22:2025.

(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. 22:2025 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. 22:2027, 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 such 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 by the commissioner of insurance subject to approval by the court, which shall not unreasonably withhold such approval.

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, 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.

Renumbered from R.S. 22:755 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1981, No. 412, § 1; Acts 2012, No. 271, § 1; Acts 2015, No. 340, § 1, eff. June 29, 2015.

Retroactive Application—Acts 2015, No. 340

Section 2 of Acts 2015, No. 340 provides:

"The provisions of Section 1 of this Act shall have retroactive application to all pending receivership proceedings."

§ 2035. 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. 22:2005(A), except Paragraphs (8) and (16) of that Subsection, 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 Chapter 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. 22:2038, the commissioner of insurance, as ancillary receiver in this state, shall be subject to the provisions of the Uniform Insurers Liquidation Law, R.S. 22:2038 through 2044.

Renumbered from R.S. 22:756 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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; Acts 2012, No. 271, § 1.

§ 2036. 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 this Chapter, and that the interests of creditors, policyholders, or the public will probably be endangered by delay, then the Nineteenth Judicial District Court for 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. 22:2006 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 five hundred dollars 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.

Renumbered from R.S. 22:756.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 82, § 1. Amended by Acts 1991, No. 742, § 1; Acts 1992, No. 808, § 1, eff. July 7, 1992; Acts 1993, No. 955, § 1; Acts 2012, No. 271, § 1; Acts 2012, No. 468, § 1.

§ 2037. Payments to Insurance Guaranty Association

The commissioner of insurance shall make periodic partial payments to the Insurance Guaranty Association.

Renumbered from R.S. 22:756.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 83, § 1.

§ 2038. Uniform Insurers Liquidation Law

This Section, and R.S. 22:2039 through 2044, 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, 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 R.S. 22:781 and 914, 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 R.S. 22:781 and 914, 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.

Renumbered from R.S. 22:757 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 785, § 1; Acts 2012, No. 271, § 1.

§ 2039. 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.

Renumbered from R.S. 22:758 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1992, No. 808, § 1, eff. July 7, 1992; Acts 1993, No. 955, § 1.

§ 2040. 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. 22:2041 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.

Renumbered from R.S. 22:759 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2041. 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.

Renumbered from R.S. 22:760 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2042. 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 Chapter, 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 R.S. 22:781 and 914, 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.

Renumbered from R.S. 22:761 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 785, § 1.

§ 2043. 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.

Renumbered from R.S. 22:762 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2043.1. Actions by and against the receiver

A. No prior wrongful or negligent actions of any present or former officer, manager, director, trustee, owner, employee, or agent of the insurer may be asserted as a defense to a claim by the receiver under a theory of estoppel, comparative fault, intervening cause, proximate cause, reliance, mitigation of damages, or otherwise. However, the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract. A principal under a surety bond or a surety undertaking shall be entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that the receiver has possession or control of the property or the insurer or its agents misappropriated or commingled such property. Evidence of fraud in the inducement shall be admissible only if it is contained in the records of the insurer.

B. No action or inaction by the insurance regulatory authorities may be asserted as a defense to a claim by the receiver.

C. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the department or its employees, or the commissioner or his designee in his capacity as receiver, liquidator, rehabilitator or conservator, or otherwise, or any special deputy, the receiver's assistants or contractors, or the attorney general's office for any action taken by them in performance of their powers and duties under this Code.

Added by Acts 2012, No. 468, § 1.

§ 2044. Uniformity of interpretation

This Uniform Insurers Liquidation Law, R.S. 22:2038 through 2044, shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it.

Renumbered from R.S. 22:763 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§§ 2045 to 2050. Reserved for future legislation

CHAPTER 10. GUARANTY FUNDS

PART I. LOUISIANA INSURANCE GUARANTY ASSOCIATION LAW

Prospective Application—Acts 2010, No. 959

Section 4 of Acts 2010, No. 959 (§ 1 of which amended and enacted various provisions within this Part I of Chapter 10 of Title 22, and § 3 of which repealed par. (A)(3) of R.S. 22:2060) provides:

"Section 4. This Act, in its entirety, is intended to have prospective application only. However, the provisions of R.S. 22:2055(15) in this Act with regard to

group self-insurance funds formed under Subpart J of Part 1 of Chapter 10 of Title 23 of the Revised Statutes of 1950 are interpretive and intended to restate the original legislative intent with regard to such funds. Such affirmation is not intended to confer any retroactive effect whatsoever to the provisions of this Act."

Change of Heading

Pursuant to § 2 of Acts 2010, No. 959 and the statutory revision authority of the Louisiana State Law Institute, "Louisiana Insurance Guaranty Association Law" was substituted for "Insurance Guaranty Association Fund" in the Part I heading.

§ 2051. Title

This Part shall be known and may be cited as the Louisiana Insurance Guaranty Association Law.

Renumbered from R.S. 22:1375 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2052. Purpose

The purpose of this Part is to provide for the payment of covered claims under certain insurance policies with a minimum delay and a minimum financial loss to claimants or policyholders due to the insolvency of an insurer, 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.

Renumbered from R.S. 22:1376 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1992, No. 517, § 1, eff. June 25, 1992; Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2053. Scope; policy coverage determination

A. This Part shall apply to all kinds of direct insurance, except:

(1) Life, annuity, health and accident or disability insurance.

(2) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(3) Fidelity or surety bonds, bail bond contracts, or any other bonding obligations.

(4) Credit insurance, vendor's single interest insurance, or collateral protection insurance or any similar insurance which protects the interests of a creditor arising out of a creditor-debtor transaction.

(5) Insurance of warranties or service contracts including vehicle mechanical breakdown insurance or other insurance that provides for the repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides for the liability incurred by the issuer of agreements or service contracts that

provide such benefits.

(6) Title insurance.

(7) Ocean marine insurance.

(8) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk.

(9) Any insurance provided by or guaranteed by government.

(10) Property residual value insurance.

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.

Renumbered from R.S. 22:1377 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1989, No. 618, § 1; Acts 1989, No. 620, § 1; Acts 1990, No. 101, § 1; Acts 2009, No. 326, § 1, eff. Jan. 1, 2010; Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2054. Construction

This Part shall be construed to effect its purpose under R.S. 22:2052, which shall constitute an aid and guide to interpretation.

Renumbered from R.S. 22:1378 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2055. Definitions

As used in this Part:

(1) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Association" means the Louisiana Insurance Guaranty Association created under R.S. 22:2056.

(3) "Association similar to the association" means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

(4) "Commissioner" means the commissioner of insurance of this state.

(5) "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 non-management 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 a 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 that control does not exist in fact.

(6) "Covered claim" means the following:

(a) An unpaid claim, including one for unearned premiums that 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 the policy was issued by such insurer and any of the following:

(i) The claimant or insured is a resident of this state at the time of the insured event, provided that, for entities, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event.

(ii) The claimant is a self-insurer, including an arrangement or trust formed under R.S. 23:1191 et seq., and is principally domiciled in this state at the time of the insured event.

(iii) The claim is a first party claim for damage to property with a permanent location in this state.

(b) "Covered claim" shall not include:

(i) Any amount awarded as penalties, punitive or exemplary damages.

(ii) Any amount sought as a return of premium under any retrospective rating plan.

(iii) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization or plan, preferred provider organization or plan, hospital plan corporation, professional health service corporation, employee retirement fund including but not limited to plans subject to the Employee Retirement Income Security Act of 1974, Medicaid, or the self-insured portion due any self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. In addition, any person insured under a policy issued by an insolvent insurer shall likewise not be liable for any subrogation claim or any contractual indemnity claim asserted by any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization or plan, hospital plan corporation, professional health service corporation, preferred provider organization or plan, employee retirement fund including but not limited to plans subject to the Employee Retirement Income Security Act of 1974, Medicaid, self-insurer, or any other person with an interest in the claim, other than to the extent the claim exceeds the association's obligation limitations.

(iv) Any claims excluded due to the high net worth of an insured as defined in this Part.

(v) Any first party claims by an insured that is an affiliate of the insolvent insurer.

(vi) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent.

(vii) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association.

(viii) Any claim for interest.

(ix) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses.

(x) Any claim the payment of which exceeds the powers and duties of the association in R.S. 22:2058(A)(1) or is outside the scope of coverage in R.S. 22:2053(A).

(xi) Any claim by a group self-insurance fund for the amount within the self-insured retention, deductible, co-pay, or any other obligation or liability of the group self-insurance fund, stated in the policy of the insolvent insurer, or for the first three hundred thousand dollars of each claim, whichever is greater.

(7) "Insolvent insurer" means an insurer who meets both of the following criteria:

(a) Is licensed and authorized to transact insurance in this state, either at the time the policy was issued or when the insured event occurred.

(b) 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.

(8) "Insured" means any named insured, any additional insured, any vendor, lessor, or any other party identified as an insured under the policy.

(9)(a) "Member insurer" means any person who meets both of the following criteria:

(i) Is licensed and authorized to transact insurance in this state.

(ii) Since September 1, 1970, has written at least one policy of insurance to which this Part applies.

(b) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Part applies; however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license.

(10) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Part applies, including policy and membership fees, less return premiums thereon, premiums on policies not taken, 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 that the reinsurer directly writes in the state.

(11) "Person" means any natural or juridical person, company, insurer, association, organization, reciprocal or inter-insurance exchange, partnership, business, trust, corporation, or other entity, including governmental entities.

(12) "Insurance policy" means an insurance contract as defined in R.S. 22:864, and shall not include an agreement in which 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 an affiliate of the other.

(13) "Ocean marine insurance" includes marine insurance as defined in R.S. 22:47(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.

(14) "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

(15) "Self-insurer" means a person that covers its liabilities through a qualified individual or group self-insurance program created for the specific purpose of covering liabilities typically covered by insurance. A group self-insurance fund formed under R.S. 23:1191 et seq. shall not be deemed to be an insurer with respect to this Chapter.

Renumbered from R.S. 22:1379 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. 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, No. 475, § 1, eff. June 18, 1999; Acts 1999, No. 476, § 1, eff. June 18, 1999; Acts 1999, No. 477, § 1, eff. June 18, 1999; Acts 2004, No. 109, § 1; Acts 2008, No. 109, § 1; Acts 2010, No. 959, § 1, eff. July 6, 2010; Acts 2012,

No. 271, § 1.

§ 2056. Creation of the association

A. There is created a private nonprofit unincorporated legal entity to be known as the "Louisiana Insurance Guaranty Association". All member insurers defined in R.S. 22:2055 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. 22:2059 and shall exercise its powers through a board of directors established under R.S. 22:2057.

B. The association is not and may not be deemed a department, unit, agency, or instrumentality of the state for any purpose, 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. 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. 42:11 et seq. 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. 42:16 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) Information 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.

(b) Matters protected by attorney-client privilege.

(c) Matters with respect to claims or claim files, except documents contained in those files which are otherwise deemed public records.

(d) 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.

(e) Any other matters 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 association, or any member or agent thereof, or the board of directors or any member or agent thereof, if such discussion or documents would

otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

Renumbered from R.S. 22:1380 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1990, No. 968, § 1, eff. July 25, 1990; Acts 2010, No. 959, § 1, eff. July 6, 2010; Acts 2012, No. 271, § 1.

§ 2057. Board of directors

A. 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. One of the two consumer representatives may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance.

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 reasonable expenses incurred by them as members of the board of directors.

D. Any member of the board whose relationship to an insurer in receivership presents a conflict of interest shall be terminated as a board member by the commissioner and the seat declared vacant as of the date of the entry of the order of receivership.

E. If the commissioner has reasonable cause to believe that a board member failed to disclose a known conflict of interest with his duties on the board, failed to take appropriate action based on a known conflict of interest with his duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that board member pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the seat shall be declared vacant.

Renumbered from R.S. 22:1381 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1970, No. 81, § 1. Amended by 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; Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2058. Powers and duties of the association

A. The association shall:

(1)(a) Be obliged to pay covered claims pursuant to an order as provided in R.S. 22:2008(C), existing prior to the determination of the insurer's insolvency, 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.

(iii) Replacement or cancellation of the policy at the instance of the insured if the insured does so within thirty days of such determination.

(b) Satisfy such obligation by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits payable directly to or on behalf of the injured employee or his health care providers, vocational rehabilitation counselors, and similar providers under a workers' compensation insurance coverage.

(ii) An amount not exceeding ten thousand dollars per policy for a covered claim for the return of unearned premium.

(iii) An amount which is in excess of one hundred dollars and is less than five hundred thousand dollars, per claim, subject to a maximum limit of five hundred thousand dollars per accident or occurrence for all other covered claims.

(c)(i) In no event be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provision of this Part, a "covered claim" 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.

(ii) For the purpose of filing a claim under this Subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another state by the liquidator.

(d) Have no obligation to defend an insured upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit, or written notice of extinguishment of the obligation due to application of a credit.

(e)(i) Have an applicable limit per claim and per accident or occurrence which

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.

(ii) "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) To the extent of its obligation on the covered claims, have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

(3)(a)(i) Assess insurers amounts necessary to pay the obligations of the association under Paragraph (1) of this Subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations of the association, 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) 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.

(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.

(iv) The amount of the assessment shall be offset in the same manner that an offset is provided against the premium tax liability in Item (3)(b)(ii) of this Subsection, against the assessment levied by R.S. 22:1476, if 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 R.S. 22:791 et seq., 821 et seq., and 831 et seq., 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. 22:832(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 Department of Insurance paid for the previous year was less than the offset allowed under Item (3)(b)(ii) of this Subsection 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)(i) Issue to each insurer paying an assessment under this Part 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.

(ii) A certificate of contribution issued to a member company may be offset against its premium tax liability in an amount not to exceed ten percent of the assessment for the year in which the assessment was paid in full and not to exceed ten percent of the assessment per year for each of the nine calendar years following the year in which such assessment was paid in full, 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.

(iii) To the extent amounts have been written off under Item (ii) of this Subparagraph, the provisions of R.S. 22:2066 shall not apply.

(c) Not subject the premium dollars paid to an insurer by any "high net worth insured" as defined in this Part to the assessment provided for in this Section for the next calendar year. 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. The association may pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

(5) Notify claimants, insureds and other interested parties of the determination of insolvency and of their rights under this Part as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association. The association may discharge this duty by notice mailed to the last known address or notice by publication in a newspaper of general circulation when a mailing address is unavailable or insufficient.

(6)(a) Have the right to review and contest as set forth in this Subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to annul, vacate, or enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:

(i) The association is not bound by an unsatisfied settlement, release, compromise or waiver executed by an insured or the insurer, or any unsatisfied judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was executed or entered within one hundred twenty days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or executed by or taken against an insured or the insurer based on default, fraud, ill practice, collusion, the insurer's failure to defend, or the clearly excessive amount of any settlement, release, compromise, waiver or judgment considering all relevant issues including but not limited to coverage, liability, and quantum.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Item (i) of this Subparagraph, the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Part.

(iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.

(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, either on its own behalf or on behalf of an insured, have the right to apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and be permitted to defend the claim on the merits.

(7) 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.

(8) 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.

(9) Implement a system of alternative dispute resolution of lawsuits and claims.

(10) Coordinate and work in conjunction with the commissioner of insurance, or his designee 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)(a) 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.

(b) With respect to state fiscal year 2014-2015, the association is hereby

authorized to make a one-time transfer to the state general fund of the amount of such excess as determined by the board of directors. This one-time authorization is not intended to create any right or interest of the state in and to the association's funds, and the legislature hereby affirms its intent that association monies may not be considered part of the general fund of the state other than monies subject to the one-time transfer hereby authorized.

(7) Submit with the commissioner to the court having jurisdiction over an impaired or insolvent insurer a joint written plan of full or partial rehabilitation or liquidation that satisfies the court that such plan is the most cost-effective method of addressing the member insurer's impairment or insolvency, is in the best interest of the member insurer's policyholders and claimants and is in the best interests of the association, and may, upon approval of the court:

(a) Guarantee, assume, or cause to be guaranteed or assumed, including the financial undertakings necessary and proper to effect such guarantees or assumptions, any or all of the policies, contracts, or other obligations of such member insurer.

(b) Lend money to such member insurer.

C. Suits involving the association:

(1) Except for actions by the receiver, all actions relating to or arising out of this Part against the association shall be brought in the courts in this state. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Part against the association.

(2) The domicile of the association for purposes of venue is East Baton Rouge Parish. The association may, at its option, waive exceptions to venue for specific actions.

(3) 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 this Part, shall pay the reasonable expenses incurred because of the filing of the petition, including a reasonable attorney fee, subject to the following conditions:

(a) 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 this Part.

(b) 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.

D. (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.

Renumbered from R.S. 22:1382 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

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, No. 77, § 1, eff. June 9, 1999; Acts 1999, No. 475, § 1, eff. June 18, 1999; Acts 1999, No. 1327, § 1; Acts 2004, No. 109, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2008, No. 687, § 1; Acts 2010, No. 959, § 1, eff. July 6, 2010; Acts 2012, No. 271, § 1; Acts 2015, No. 274, § 1, eff. June 29, 2015.

Application—Acts 2008, No. 687

Section 2 of Acts 2008, No. 687 (§ 1 of which amended item (A)(1)(a)(iii) of this section) provides:

"Section 2. The provisions of this Act shall apply prospectively only and to covered claims which arise out of a liquidation proceeding which is commenced on or after August 15, 2008."

§ 2059. Plan of operation

A. (1) The association shall submit to the commissioner, 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, 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. 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.

(2) If 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. If a hearing is not held by such committees within thirty days after receipt of the rules and regulations promulgated by the commissioner under the

provisions of this Paragraph, then the rules and regulations may be implemented as promulgated by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

(1) Establish procedures for performing the powers and duties of the association.

(2) Establish procedures for handling assets of the association.

(3) Establish procedures for reimbursing the members of the board of directors for reasonable expenses.

(4) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims.

(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 either or both the Senate Committee on Insurance and 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.

(10) Establish procedures for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer.

(11) Establish policies and procedures designed to increase participation for minorities and women in contractual legal services entered into by the association.

(12) Establish policies and procedures relative to the appointment of legal counsel.

(13) Establish policies and procedures relative to a system of alternative dispute resolution of lawsuits and claims.

(14) Establish procedures whereby a director may be removed for cause.

D. The plan of operation may provide that any or all powers and duties of the association, except those under R.S. 22:2058(A)(3) and (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.

Renumbered from R.S. 22:1383 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1993, No. 397, § 2, eff. June 2, 1993; Acts 2010, No. 959, § 1, eff. July 6, 2010; Acts 2012, No. 271, § 1.

§ 2060. Duties and powers of the commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer no later than three days after he receives notice of the determination of the insolvency. The association shall be entitled to a copy of a petition seeking an order of liquidation with a finding of insolvency against a member company at the same time that the petition is filed.

(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) Repealed by Acts 2010, No. 959, § 3, eff. July 6, 2010.

B. The commissioner may:

(1) Suspend or revoke, after compliance with R.S. 49:961, the certificate of authority to transact insurance in this state of any member insurer that 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 that 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.

(2) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(3) Examine, audit, or otherwise regulate the association.

C. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

Renumbered from R.S. 22:1384 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1976, No. 219, § 1; Acts 1979, No. 474, § 1; Acts 2008, No. 467, § 1; Acts 2009, No. 317, § 1; Acts 2010, No. 959, § 1, eff. July 6, 2010; Acts 2012, No. 271, § 1.

§ 2060.1. Coordination among guaranty associations

A. The association may join one or more organizations of other state associations

of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.

B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Added by Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2061. 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, except with respect to the recovery of sums paid on a claim excluded due to the high net worth of an insured as defined in this Part. 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.

D. The association and any association similar to the association in another state shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Part or similar laws in other states and shall receive dividends and other distributions at the priority set forth in R.S. 22:2025.

Renumbered from R.S. 22:1385 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2061.1. Net worth exclusion

A. For purposes of this Part, "high net worth insured" shall mean any policyholder or named insured, other than any state or local governmental agency or subdivision thereof, whose net worth exceeds twenty-five million dollars on December thirty-first of the year prior to the year in which the insurer becomes an insolvent insurer if an insured's net worth on that 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. The consolidated net worth of the insured and all of its affiliates shall be calculated on the basis of their fair market values. The members of a group self-insurance fund formed pursuant to R.S. 23:1191 et seq. shall not be deemed to be affiliates of the fund, and shall not be included in the determination of the net worth of the fund. For the purposes of this Section, a group self-insurance fund, and each individual member of the fund upon whose behalf a claim is submitted, shall be deemed to be policyholders or named insureds of any policy of insurance issued to the fund.

B. (1) The association shall not be obligated to pay any claims or provide a defense to any claims asserted for coverage under a policy when the insured is a high net worth insured.

(2) The association shall have the right to recover from a high net worth insured all costs incurred and all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise, including attorney fees, administrative costs, court costs, settlement, or other defense costs.

C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the state of residence of the claimant at the time specified by that state's applicable law, and which association has denied coverage to that claimant on that basis.

D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this Section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B of this Section.

E. In any lawsuit contesting the applicability of this Section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D of this Section, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorney fees in contesting the claim.

Added by Acts 2010, No. 959, § 1, eff. July 6, 2010. Amended by Acts 2012, No.

271, § 1.

§ 2062. Exhaustion of other coverage

A. (1) Any person having a claim against an insurer shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether or not the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy or annuity.

(2) Any amount payable on a covered claim under this Part shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association and the insured shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association and the insured shall receive a full credit for the total recovery.

(a) The credit shall be deducted from the lesser of the following:

(i) The association's covered claim limit.

(ii) The amount of the judgment or settlement of the claim.

(iii) The policy limits of the policy of the insolvent insurer.

(b) In no case, however, shall the obligation of the association exceed the covered claim limit of this Part.

(3) If the insured or claimant has a contractual right to claim defense under an insurance policy issued by another insurer, including a self-insurer, the insured or claimant shall first exhaust all rights to indemnity and defense under such policy before claiming indemnity or defense from the association, or the insured of the insolvent insurer. The association's duty to defend under the policy issued by the insolvent insurer is subject to any other limitation on the duty to defend in this Part. This duty is secondary to the obligation of any other insurer or self-insurer to provide a defense, whose duty to the claimant is primary.

(4) A claim under a policy providing liability coverage to a person who may be solidarily liable as a tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this Section, a claim under an insurance policy other than a life insurance policy or annuity shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy, liability coverage, uninsured or underinsured motorist liability coverage, hospitalization, coverage under self-insurance certificates, preferred provider organization, or similar plan, and any and all other medical expense coverage.

(b) Any amount payable by or on behalf of a self-insurer.

(c) Any claim against persons prohibited from recovering against the association as specified in this Part.

(6) 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, any and all other insurance available to the insured for the claim for all policy periods for which insurance is available must first be exhausted before recovering from the association, even if an insolvent insurer provided the only coverage for one or more policy periods of the alleged exposure. Only after exhaustion of all solvent insurer's total policy aggregate limits for any alleged exposure periods will the association be obligated to provide a defense and indemnification within the obligations of this Part, subject to a credit for the total amount thereof, whether or not the total amount has actually been paid or recovered.

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. For purposes of this Section, the "residence of the insured" shall be the residence, on the date of insolvency of the insurer or self-insurer, of the first named or primary insured or the state to which the insolvent insurer or self-insurer was or would have been liable for the payment of a surcharge or assessment on the subject insurance policy to an insurance guaranty association or its equivalent. 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.

Renumbered from R.S. 22:1386 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1990, No. 130, § 1; Acts 1992, No. 237, § 2, eff. June 10, 1992; Acts 1999, No. 477, § 1, eff. June 18, 1999; Acts 2004, No. 108, § 1; Acts 2010, No. 959, § 1, eff. July 6, 2010; Acts 2012, No. 271, § 1.

§ 2063. Prevention of insolvencies

To aid in the detection and prevention of insurer insolvencies:

(1) The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

(2) At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon a majority vote, 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.

Renumbered from R.S. 22:1387 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2064. 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.

Renumbered from R.S. 22:1388 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1997, No. 468, § 1, eff. June 26, 1997.

§ 2065. 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.

Renumbered from R.S. 22:1389 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1.

§ 2066. 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.

Renumbered from R.S. 22:1390 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1.

§ 2067. 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. This 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.

Renumbered from R.S. 22:1391 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2068. 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 six months and such additional time as may be determined by the court from the date the insolvency is determined to permit proper defense by the association of all pending causes of action.

B. The liquidator, receiver or statutory successor of an insolvent insurer covered by this Part shall permit access by the association to such of the insolvent insurer's records that are necessary to carry out its functions under this Part and shall provide the association with copies of those records upon request by and at the expense of the association.

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. 22:2058(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.

Renumbered from R.S. 22:1392 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1990, No. 102, § 1; Acts 1991, No. 222, § 1, eff. July 2, 1991; Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2069. Advertisements

A. Advertisements which include a reference to the coverage or protection by the Louisiana Insurance Guaranty Association are specifically prohibited.

B. As used in this Section, "advertisements" means any communication by print, television, radio, Internet, 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.

Renumbered from R.S. 22:1393 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1. Amended by Acts 1990, No. 260, § 1; Acts 2010, No. 959, § 1, eff. July 6, 2010.

§ 2070. Effective date

The provisions of this Part shall become effective on September 1, 1970.

Renumbered from R.S. 22:1394 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1970, No. 81, § 1.

PART II. LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION FUNDS

§ 2081. Title; construction

This Part shall be known and may be cited as the "Louisiana Life and Health Insurance Guaranty Association Law" and shall be construed to effect the purpose under R.S. 22:2082.

Renumbered from R.S. 22:1395.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1.

§ 2082. Purpose

A. The purpose of this Part is to protect, subject to certain limitations, the persons listed in R.S. 22:2083(A) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in R.S. 22:2083(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.

Renumbered from R.S. 22:1395.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991.

§ 2083. 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, other than a structured settlement annuity, and who is either:

(a) A resident.

(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.

(3) For structured settlement annuities specified in Subsection B of this Section, Paragraphs (1) and (2) of this Subsection shall not apply, and this Part shall, except as provided in Paragraphs (4) and (5) of this Subsection, provide coverage to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, if the payee is one of the following:

(a) A resident, regardless of where the contract owner resides.

(b) Not a resident, but only under both of the following conditions:

(i) The contract owner of the structured settlement annuity either is a resident or is not a resident and meets both of the following conditions in the case where the contract owner is not a resident:

(aa) The insurer that issued the structured settlement annuity is domiciled in this state.

(bb) The state in which the contract owner resides has an association similar to the association created by this Part.

(ii) Neither the payee, or the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This Part shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state.

(5) This Part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Part is provided coverage under the laws of any other state, the person shall not be provided coverage under this Part. In determining the application of the provisions of this Paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary or assignee, this Part shall be construed in conjunction with other state laws to result in coverage by only one association.

B. (1) This Part shall provide coverage to the persons specified in Subsection A of this Section for direct non-group life, health, or annuity policies or contracts, for certificates under direct group policies and contracts for supplemental contracts to any of these, and for unallocated annuity contracts, in each case 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, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(i) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this Part, whichever is earlier, exceeds the 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 contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this Part, whichever is earlier.

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this Part, whichever is earlier, 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 to an employer, association, or similar entity under:

(i) A Multiple Employer Welfare Arrangement as defined in 29 U.S.C. § 1002(40) (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)).

(h) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitations, any of the following:

(i) Claims based upon marketing materials.

(ii) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements.

(iii) Misrepresentations of or regarding policy benefits.

(iv) Extra-contractual claims.

(v) A claim for penalties or consequential or incidental damages.

(i) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly referred to as "Medicare Part C coverage" and "Medicare Part D coverage" and any regulations issued pursuant to those parts.

(j) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Part, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this Paragraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture.

C. The benefits for which the association shall become liable shall in no event exceed the lesser of the following:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer.

(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) Five hundred thousand dollars in health insurance benefits.

(c) Two hundred fifty 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 five hundred thousand dollars in the aggregate with respect to any one individual under Subsection C of this Section.

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. 40:1231.1, 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.

Renumbered from R.S. 22:1395.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1; Acts 2014, No. 374, § 1.

§ 2084. Definitions

As used in this Part:

(1) "Account" means any of the four accounts created by R.S. 22:2085(A).

(2) "Association" means the Louisiana Life and Health Insurance Guaranty Association created by R.S. 22:2085.

(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. 22:2083.

(5) "Covered policy" means any policy or contract within the scope of this Part as set forth by R.S. 22:2083.

(6) "Impaired insurer" means a member insurer which, after September 30, 1991,

is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(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. 22:2083, 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 hospital or medical service organization, whether operated for profit or as a nonprofit.

(g) An organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3).

(h) 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. 22:2083(B), except that accessible premiums shall not be reduced on account of R.S. 22:2083(B)(2)(c)(ii) relating to interest limitations with respect to any one individual, any one participant, and any one policyholder.

(11.1) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(12) "Resident" means a person who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an 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. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this Part, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(12.1) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(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.

Renumbered from R.S. 22:1395.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 1994, 3rd Ex.Sess., No. 92, § 1; Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1; Acts 2014, No. 374, § 1.

§ 2085. 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. 22:2089 and shall exercise its powers through a board of directors established by R.S. 22:2086. 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 R.S. 24:513 et seq. regarding audits by the legislative auditor. The form established by the commissioner pursuant to R.S. 22:2064 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. 42:11 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. 42:16 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. 22:2091.

(b) Reports and recommendations made by the association to the commissioner pursuant to R.S. 22:2093 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, if such discussion or documents would otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

Renumbered from R.S. 22:1395.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 1992,

No. 115, § 1; Acts 1997, No. 534, § 1, eff. July 3, 1997; Acts 2012, No. 271, § 1.

§ 2086. Board of directors

A. The board of directors of the association shall consist of one consumer representative appointed by the commissioner subject to Senate confirmation, who shall be a resident of the state of Louisiana, and ten member insurers serving terms as established in the plan of operation. The consumer representative may not be an officer, director, or employee of an insurance company or engaged in the business of insurance. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner from the following groups or their successors:

(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 Insurers.

(3) One representative of a member insurer selected from recommendations of America's Health Insurance Plans.

(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 American Council of Life Insurers Forum 500.

(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.

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 reasonable expenses incurred by them as members of the board of directors. The members of the board shall otherwise not be compensated by the association for their services.

Renumbered from R.S. 22:1395.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 1994, 3rd Ex.Sess., No. 92, § 1; Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1.

§ 2087. Powers and duties of the association

A. If a member insurer is an impaired 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 and 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, loans, guarantees, or other means as are proper to effectuate Paragraph (1) of this Subsection and assure payment of the contractual obligations of the impaired insurer pending action under Paragraph (1) of this Subsection.

B. If a member insurer is an insolvent insurer, the association shall, in its discretion, perform any of the following:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer.

(2) Assure payment of the contractual obligations of the insolvent insurer.

(3) Provide such monies, pledges, notes, loans, guarantees, or other means as are reasonably necessary to discharge such duties.

(4) Provide benefits and coverages in accordance with Subsection C of this Section.

C. With respect to life and health insurance policies and annuities, the association shall:

(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 or contracts of the insolvent insurer, for claims incurred.

(a) With respect to group policies and contracts, not later than the earlier of the 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 and contracts.

(b) With respect to non-group policies, contracts, and annuities, not later than the earlier of the next 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 or contracts.

(2) Make reasonable and diligent efforts to provide all known insureds or annuitants for non-group policies and contracts, or group policyholders with respect to group policies and contracts, thirty days prior notice of the termination of the benefits provided.

(3) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant 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 Paragraph (4) of this Subsection, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right to unilaterally alter any provision of the policy or annuity or had a right to undertake alterations only in premium by class.

(4)(a) In providing the substitute coverage required under Paragraph (3) of this Subsection, 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 terminated policy.

(c) The association may reinsure any alternative or reissued policy.

(5)(a) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(b) Alternative policies shall contain at least the minimum statutory provisions required in this state and 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 that it shall adopt. 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 approval of the domiciliary insurance commissioner and the receivership court.

(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 the coverage or policy is replaced by another similar policy by the policy owner, the insured, or the association.

(8) When proceeding under this Subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the

payment or crediting of a rate of interest consistent with R.S. 22:2083(B)(2)(c).

D. Repealed by Acts 2014, No. 374, § 2.

E. Repealed by Acts 2014, No. 374, § 2.

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. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premiums collected by the association. 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 Subsections (B) and (C) of this Section, 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 Subsections B and C of this Section, 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 or intervene before any court in this state or state agency with jurisdiction over an impaired or insolvent insurer and concerning which the association shall become obligated under this Part or with jurisdiction over any other person or property against which the

association may have benefit through subrogation or otherwise. 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 or agency in another state with jurisdiction over any person or property for which the association shall become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation or otherwise.

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 Paragraphs (1) and (2) of this Subsection, 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.

(4) If the provisions of this Subsection are determined to be invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related, covered obligations shall be reduced by the amount realized by any other person or claim that is attributable to the policies, or portion thereof, covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in Paragraph (4) of this Subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or the portion thereof, covered by the association.

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. 22:2088 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 or recover 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.

P. (1) Venue in a suit against the association arising under this Part shall be in the Nineteenth Judicial District.

(2) The association shall not be required to furnish an appeal bond that relates to a cause of action arising under this Part.

Q. In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under this Section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract that meets the following requirements:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for one of the following:

(a) A fixed interest rate.

(b) Payment of dividends with minimum guarantees.

(c) A different method for calculating interest or changes in value.

(2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract.

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Renumbered from R.S. 22:1395.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1; Acts 2014, No. 374, § 1.

§ 2088. 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. 22:2091. 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. 22:2087 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 three hundred 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 this Section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

E. (1)(a) 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.

(b) With respect to insurers that become impaired or insolvent in different calendar years, if two or more assessments are authorized in one calendar year, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in Subparagraph (a) of this Paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated pursuant to this Section.

(c) 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.

I. (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within thirty days after the final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

J. The association may request information of member insurers in order to aid in the exercise of its powers under this Section and member insurers shall promptly comply with a request.

Renumbered from R.S. 22:1395.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1.

§ 2089. 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 at any time 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 superceded 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. 22:2086.

(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. 22:2088.

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(8) Establish procedures by which a director may be removed for cause, including but not limited to the case where the director of a member insurer becomes impaired or insolvent.

(9) Require the board of directors to establish policy and procedures for addressing conflicts of interest.

D. The plan of operation may provide that any or all powers and duties of the association, except those under R.S. 22:2087(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.

Renumbered from R.S. 22:1395.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1.

§ 2090. 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 compliance with R.S. 49:961, 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 or insolvent insurer shall notify all interested persons of the effect of this Part.

Renumbered from R.S. 22:1395.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2009, No. 317, § 1.

§ 2091. 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 Paragraph (1) of this Subsection 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 Subsection A of this Section.

(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.

Renumbered from R.S. 22:1395.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2012,

No. 271, § 1.

§ 2092. Offsets for assessments paid

A. An insurer may offset against any premium 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. 22:131 through 135 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. 22:832(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 Subsection A of this Section 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.

Renumbered from R.S. 22:1395.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1.

§ 2093. 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. 22:2094.

C. (1) 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. 22:2087(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.

(2) As a creditor of the impaired or insolvent insurer as established in Paragraph (1) of this Subsection and consistent with R.S. 22:2034, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this Part. If the liquidator has not, within one hundred and twenty days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guarantee associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

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 Paragraphs (2) and (4) of this Subsection.

(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. 22:2092(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 solidarily 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 solidarily liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Renumbered from R.S. 22:1395.13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1.

§ 2094. 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.

Renumbered from R.S. 22:1395.14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991.

§ 2095. 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.

Renumbered from R.S. 22:1395.15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991.

§ 2096. 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 employees, 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.

Renumbered from R.S. 22:1395.16 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991.

§ 2097. 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 one hundred eighty 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.

Renumbered from R.S. 22:1396.17 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 2009, No. 258, § 1.

§ 2098. Prohibited advertisement of Louisiana Life and Health 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 Law. 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. 22:2092(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. 22:2083(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 Subsection D of this Section 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 Subsection B of this Section 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. 22:2083(B)(1) and excluded by R.S. 22:2083(B)(2) 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.

Renumbered from R.S. 22:1395.18 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991. Amended by Acts 1994, 3rd Ex.Sess., No. 92, § 1; Acts 2009, No. 258, § 1; Acts 2012, No. 271, § 1; Acts 2014, No. 374, § 1.

§ 2099. 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.

Renumbered from R.S. 22:1395.19 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1991, No. 998, § 1, eff. Sept. 30, 1991.

CHAPTER 11. COMMISSIONS AND ASSOCIATIONS

PART I. FIRE INSURANCE PATROL ASSOCIATIONS

§ 2111. Definitions

For purposes of this Part, the term "association" means a fire insurance patrol association organized under this Part, except where the context clearly indicates otherwise.

Renumbered from R.S. 22:1551 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2112. Formation of fire insurance patrol associations

A. 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.

B. 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.

Renumbered from R.S. 22:1552 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2113. Officers; management

A. 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.

B. The management of the associations organized under the provisions of this Part is vested in the board of directors or executive committee.

Renumbered from R.S. 22:1553 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2114. Certificate of approval

Immediately after organization of an association pursuant to this 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 bylaws and a certified list of the fire insurance companies subscribing thereto. If the organization is found to conform to the provisions of this Part, the commissioner of insurance shall furnish the association with a certificate of approval.

Renumbered from R.S. 22:1554 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2115. 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 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.

Renumbered from R.S. 22:1555 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2116. 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.

Renumbered from R.S. 22:1556 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2117. 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.

Renumbered from R.S. 22:1557 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2118. Annual statements by fire insurers; assessments for expenses of associations

A. 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 thirty-first 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.

B. 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 percent 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.

Renumbered from R.S. 22:1558 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2119. 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. 22:2118 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 percent of the amount collected and paid over.

Renumbered from R.S. 22:1559 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2012, No. 271, § 1.

§ 2120. 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. 22:2119 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. 22:2119 have first been complied with.

Renumbered from R.S. 22:1560 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

PART II. LOUISIANA AUTOMOBILE THEFT AND INSURANCE FRAUD PREVENTION AUTHORITY

§ 2131. Definitions

As used in this Part:

(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.

Renumbered from R.S. 22:3201 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 711, § 1, eff. Aug. 15, 2004.

§ 2132. 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 and Auto Theft 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 and Auto Theft 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. 42:11 et seq.), and public bid

(R.S. 38:2211 et seq.).

Renumbered from R.S. 22:3202 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 711, § 1, eff. Aug. 15, 2004. Amended by Acts 2012, No. 271, § 1.

§ 2133. Authority; further powers and duties

The authority shall have the powers necessary and convenient to implement and effectuate the purposes and provisions of this Part 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, such gifts, grants, donations, loans, and other assistance to be immediately deposited upon receipt into the fund provided for in R.S. 22:2134(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 Part into the Automobile Theft and Insurance Fraud Prevention Authority Fund, provided for in R.S. 22:2134.

(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 Part.

Renumbered from R.S. 22:3203 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Added by Acts 2004, No. 711, § 1, eff. Aug. 15, 2004. Amended by Acts 2012, No. 271, § 1.

§ 2134. 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 Part 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 Part 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 Part, 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 and public awareness programs designed to inform the citizens of the state about methods of preventing motor vehicle theft and combating 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.

Renumbered from R.S. 22:3204 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 711, § 1, eff. Aug. 15, 2004. Amended by Acts 2010, No. 1013, § 1, eff. July 1, 2010.

§ 2135. Plan of operation

A. The authority shall develop and implement a plan of operation upon the recommendations of the director.

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.

Renumbered from R.S. 22:3205 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 711, § 1, eff. Aug. 15, 2004. Amended by Acts 2012, No. 271, § 1.

PART III. LOUISIANA CONSORTIUM OF INSURANCE AND FINANCIAL SERVICES

§ 2141. 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. 22:2147 and shall exercise its powers through a board of directors with the advice and consent of an advisory committee.

Renumbered from R.S. 22:1194 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995.

§ 2142. 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.

Renumbered from R.S. 22:1194.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995.

§ 2143. 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.

Renumbered from R.S. 22:1194.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995. Amended by Acts 2004, No. 286, § 1.

§ 2144. 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.

Renumbered from R.S. 22:1194.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995.

§ 2145. 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.

Renumbered from R.S. 22:1194.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995.

§ 2146. 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.

Renumbered from R.S. 22:1194.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995.

§ 2147. 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 at any time the consortium fails to submit suitable amendments to the plan, the commissioner may, after notice and public 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 superceded 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. 22:2143 and 2144 will be performed.

(3) Establish the amount and method of reimbursing the members under R.S. 22:2143 and 2144.

(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.

Renumbered from R.S. 22:1194.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995. Amended by Acts 2009, No. 317, § 1; Acts 2012, No. 271, § 1.

§ 2148. 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. 22:2145 and 2146, 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.

Renumbered from R.S. 22:1194.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1995, No. 710, § 1, eff. Sept. 1, 1995.

PART IV. LOUISIANA HEALTH CARE COMMISSION

§ 2161. Louisiana Health Care Commission; creation

A. 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. 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 Association for Justice.

(7) Health Agents for America.

(8) Agenda for Children.

(9) Independent Insurance Agents & Brokers of Louisiana.

(10) AARP Louisiana.

(11) The National Federation of Independent Businesses.

(12) Repealed by Acts 2012, No. 271, § 2.

(13) Louisiana Independent Pharmacies Association.

(14) AARP, the nominee of which shall be a volunteer representative.

(15) Louisiana Association of Business and Industry.

(16) Louisiana Health Plan.

(17) NAIFA Louisiana.

(18) League of Women Voters.

(19) Louisiana Hospital Association.

(20) Louisiana Primary Care Association.

(21) Repealed by Acts 2014, No. 90, § 2.

(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) Repealed by Acts 2012, No. 271, § 2.

(35) National Medical Association.

(36) National Association for the Advancement of Colored People.

(37) Repealed by Acts 2012, No. 271, § 2.

(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 Subsection 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.

Renumbered from R.S. 22:9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1992, No. 1068, § 1. Amended by Acts 1993, No. 665, § 1; Acts 1995, No. 594, § 1; Acts 1997, No. 869, § 1; Acts 1999, No. 446, § 1, eff. July 1, 1999; Acts 2001, No. 67, § 1, eff. May 24, 2001; Acts 2004, No. 495, § 1; Acts 2012, No. 271, § 1; Acts 2014, No. 90, § 1.

PART V. LOUISIANA PROPERTY AND CASUALTY INSURANCE COMMISSION

§ 2171. Louisiana Property and Casualty Insurance Commission

A. The legislature hereby creates the Louisiana Property and Casualty Insurance Commission within the 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.

C. The commission shall consist of the following members:

(1) The governor or his designee.

(2) The deputy commissioner for consumer advocacy.

(3) The assistant secretary of the 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 Property Casualty Insurers Association of America, selected by its governing body, or his designee.

(8) A representative of the Louisiana Surplus Line Association, selected by its governing body, 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 & Brokers 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 Louisiana Workforce Commission, office of workers' compensation or his designee, appointed by the executive director.

(19) The commissioner of insurance or his designee.

(20) A representative of the National Association of Mutual Insurance Companies.

(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 Sheriffs' Association.

(22) One member selected by the commissioner of insurance.

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) The representative of the National Association of Mutual Insurance Companies.

(4) The assistant secretary of the 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 Property Casualty Insurers Association of America 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 & Brokers of Louisiana.

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

(16) Repealed by Acts 2007, No. 459, § 3, eff. Jan. 1, 2008.

(17) Repealed by Acts 2012, No. 271, § 2.

(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 & Brokers of Louisiana.

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

(7) The representative of the National Association of Mutual Insurance Companies.

(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 Property Casualty Insurers Association of America 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 & Brokers of Louisiana.

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

(7) The representative of the National Association of Mutual Insurance Companies.

(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 Louisiana Workforce Commission, office of workers' compensation or his designee, appointed by the executive director.

(12) The representative of the Property Casualty Insurers Association of America or his designee.

(13) Repealed by Acts 2012, No. 271, § 2.

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. 42:11 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 of the commissioner of insurance.

Renumbered from R.S. 22:15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 1433, § 1. Amended by Acts 1999, No. 885, § 1, eff. June 30, 1999; Acts 2001, No. 187, § 1, eff. July 1, 2001; Acts 2003, No. 590, § 1; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2012, No. 271, § 1; Acts 2012, No. 317, § 1; Acts 2014, No. 223, § 1.

PART VI. LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER HEALTH MAINTENANCE ORGANIZATION

§ 2181. 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 Subpart I of Part I of Chapter 2 of this Title, R.S. 22:241 et seq. The minimum financial requirements and the requirements for incorporation provided in such Subpart I 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.

Renumbered from R.S. 22:3021 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 3, § 2, eff. July 1, 1997. Amended by Acts 1999, No. 802, § 2, eff. July 2, 1999; Acts 2012, No. 271, § 1.

§ 2182. 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.

Renumbered from R.S. 22:3022 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1997, No. 3, § 2, eff. July 1, 1997. Amended by Acts 1999, No. 802, § 2, eff. July 2, 1999.

PART VII. LOUISIANA MANDATED HEALTH BENEFITS COMMISSION

§ 2186. Purpose; legislative intent

There are currently approximately twenty statutes in Louisiana that mandate coverage in health insurance plans for various services, plus other laws that mandate coverage for services rendered by certain types of providers or that mandate health insurers to offer certain benefits. Mandated benefits represent a volatile issue for the legislature. Proponents cite the need of certain individuals for such benefits and the possible public good, while opponents express concern about additional cost to consumers and employers and the potential effect of those costs on the level of uninsured in the state. The legislature recognizes the need for a more studied approach to consideration of such measures, an approach that would ensure that broad-based views of healthcare stakeholders, including consumers, employers, health care providers, and others, are considered.

Added by Acts 2010, No. 549, § 1.

§ 2186.1. Louisiana Mandated Health Benefits Commission

A. The Louisiana Mandated Health Benefits Commission is hereby created, and shall exercise its powers, duties, functions, and responsibilities in the manner provided in R.S. 36:802. The commission shall be staffed by the office of health insurance of the Department of Insurance, assisted by the legislative staffs of the House and Senate committees on insurance.

B. The commission shall be comprised of the following members representing the diverse interest of business, consumers and health care providers:

(1) Voting members, who shall serve without compensation, as follows:

(a) A representative of AARP.

(b) A representative of the Louisiana AFL-CIO.

(c) A representative of the Louisiana Coalition for Maternal and Infant Health.

(d) A representative of the Louisiana Association of Business and Industry.

(e) A representative of the Louisiana Association of Health Plans.

(f) A representative of the Louisiana Association of Health Underwriters.

(g) A representative of the Louisiana Business Group on Health.

(h) A representative of the Louisiana Hospital Association.

(i) A representative of the Louisiana State Medical Society.

(j) A representative of the National Federation of Independent Business.

(k) A representative of the National Association of Insurance and Financial Advisors.

(l) A representative of the Office of Group Benefits.

(m) An additional consumer representative, appointed by the chairman of the Senate Committee on Insurance.

(n) An additional consumer representative, appointed by the chairman of the House Committee on Insurance.

(o) A representative of the Louisiana Small Business Association.

(p) A representative of the Chiropractic Association of Louisiana.

(q) A representative of the Louisiana Independent Pharmacies Association.

(r) A representative of the Louisiana Orthopaedic Association.

(2) Ex officio members, who shall be nonvoting members, as follows:

(a) A member of the Senate Committee on Insurance, appointed by the chairman of that committee.

(b) A member of the House Committee on Insurance, appointed by the chairman of that committee.

(3) Other nonvoting members, as follows:

(a) A representative of the legislative fiscal office.

(b) An actuary appointed by the commissioner of insurance.

C. The commission shall conduct its duties under the direction of the commissioner of insurance. The commission shall elect its own chair, who shall preside at meetings, and a vice chair, who shall preside in the absence of the chair. The commission shall conduct its business according to *Robert's Rules of Order*. A

quorum for conducting business shall be a majority of the voting members. Recommendations of the commission shall be determined by simple majority vote of the voting members present. The commission is authorized to create further rules in compliance with state law for the conduct of its business.

D. The duties of the commission may encompass:

(1) An optional review of all proposed legislation that would mandate coverage by health insurance issuers of specifically enumerated benefits, services, conditions, or medical products. For purposes of this Section, such legislation shall be referred to as "mandated benefits proposals".

(2) To annually report findings and recommendations, if any, on mandated benefits proposals to the legislature.

E. The commission shall consider the following factors when reviewing mandated benefits proposals:

(1) Medical impacts, including:

(a) Whether the service or product is generally recognized in the medical community as effective in screening, diagnosis, or treatment of a condition, as demonstrated by a review of scientific and peer-reviewed medical literature.

(b) Whether the service or product is currently utilized by treating health care providers.

(2) Social impacts, including:

(a) The level of public demand for the coverage of the service or product.

(b) The extent to which coverage for the service or product is already being provided.

(c) Projected short-term and long-term good for the state and its people.

(3) Financial impacts, including:

(a) The projected cost of providing coverage of the service or product, the projected effect of such mandated coverage on health insurance premiums, and the potential impact of additional costs on the level of uninsured in the state.

(b) The projected increase in utilization of the service or product.

(c) The projected cost savings produced by providing coverage of the service or product.

F. (1) The commission shall meet annually, no later than sixty days prior to the date that the regular session of the legislature convenes for that year to review proposals received by January fifteenth.

(2) Additional meetings may be held at other times during the year, if necessary, to properly consider mandated benefit proposals.

(3) Notice of commission meetings shall be made according to state law.

(4) The commission shall report its findings to the House and Senate committees on insurance no later than thirty days prior to the date that the regular session of the legislature convenes.

(5) The commission shall, as soon as practicable, consider, analyze and report to the House and Senate committees on insurance prior to the regular legislative session on proposed mandated benefits submitted to the commission after January fifteenth each year.

(6) The House and Senate committees on insurance shall take into account the commission's report on a particular mandated benefit proposal when such proposal is brought before the committees for consideration.

G. The commission shall provide an opportunity for any interested person to present information regarding a mandated benefit proposal as part of the commission's consideration of a proposal and prior to the commission's report to the legislature. The commission may, as it deems appropriate, request reports related to proposed mandated benefits from persons outside the commission.

Added by Acts 2010, No. 549, § 1.

CHAPTER 12. ADMINISTRATIVE ORDERS, HEARINGS AND APPEALS

§ 2191. Hearings

A. The division of administrative law shall hold a hearing in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall hold a hearing under either of the following circumstances:

(1) If required by any provision of this Code.

(2) Upon written demand for a hearing made by any person aggrieved by any act, order of the commissioner, 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.

B. (1) Any such demand for a hearing shall be filed with the division of administrative law and with the commissioner within thirty days after notice of such act or order is mailed, faxed, or delivered to the aggrieved party at his last known address specifying 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. The aggrieved person shall reference the particular sections of the statutes and rules involved, shall provide a short and plain statement of matters asserted for review, and shall attach a copy of any order or decision of the commissioner for review.

(2) The division of administrative law shall hold such hearing demanded within thirty days after receipt of the demand, unless postponed by mutual consent, or upon motion of either party for good cause shown or as ordered by the division of administrative law. 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. This Chapter shall not apply to public hearings held by the commissioner unless otherwise provided. The commissioner may promulgate procedures, rules, and regulations for the conduct of any public hearing in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Renumbered from R.S. 22:1351 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1964, No. 150, § 1; Acts 1992, No. 695, § 1; Acts 2009, No. 317, § 1. Amended by Acts 2012, No. 271, § 1.

§ 2192. Repealed by Acts 2009, No. 317, § 2

§ 2193. Hearing place

All division of administrative law hearings shall be held at the place designated by the division of administrative law and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Renumbered from R.S. 22:1353 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 317, § 1.

§ 2194. Notice of hearing

A. Notice of any division of administrative law hearing shall be issued by the division of administrative law in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

B. (1) If notice of a hearing would be required to be given to more than one hundred persons, in lieu of the notice provided for in Subsection A of this Section and for the purposes of Part IV of Chapter 7 of this Title, R.S. 22:1961 et seq., only, the division of administrative law 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.

(2) Any such published notice shall state the time and place of the hearing and shall specify the matters to be considered at the hearing.

Renumbered from R.S. 22:1354 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 153, § 1; Acts 2009, No. 317, § 1.

§ 2195. Notice of wrongful conduct; opportunity to show cause

If any person is entitled to a hearing pursuant to any provision of this Code, the commissioner shall issue a notice of wrongful conduct prior to the taking of any regulatory action. The notice shall contain allegations of fact describing the wrongful conduct and cite the provisions of law that the commissioner deems to have been violated. The notice shall also inform the person of the opportunity to show cause, in a manner specified in the notice, as to why regulatory action should not be taken.

Renumbered from R.S. 22:1355 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts

1958, No. 125. Amended by Acts 2015, No. 15, § 1, eff. May 26, 2015.

§ 2196. Repealed by Acts 2009, No. 317, § 2

§ 2197. 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.

Renumbered from R.S. 22:1357 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125.

§ 2198. Procedure and subpoena power of commissioner

A. 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 at a hearing or investigation proceeding, 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 a hearing, inquiry, or investigation.

B. If a person subpoenaed to attend such hearing, proceeding, or investigation 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 one hundred dollars nor more than two thousand dollars 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.

C. 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.

D. 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.

Renumbered from R.S. 22:1358 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1964, No. 153, § 1; Acts 2009, No. 317, § 1.

§§ 2199 to 2203. Repealed by Acts 2009, No. 317, § 2

§ 2204. Stay of action on review

A. A demand for a hearing or a hearing proceeding shall not stay any order issued by the commissioner or stay any action taken or proposed to be taken by the commissioner of insurance under the act or order complained of unless a stay is granted by the division of administrative law at a hearing held as part of the proceedings in accordance with the Administrative Procedure Act, R.S. 49:950. Any stay must be requested by the party seeking a hearing.

B. A stay shall not be granted by the division of administrative law 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 and in accordance with the Administrative Procedure Act, R.S. 49:950.

Renumbered from R.S. 22:1364 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1993, No. 956, § 1; Acts 2009, No. 317, § 1.

§ 2205. Appeal

All appeals from a decision of the division of administrative law shall be in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Renumbered from R.S. 22:1365 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 2009, No. 317, § 1; Acts 2012, No. 271, § 1.

§ 2206. Use of injunctive process

Notwithstanding any law to the contrary, the commissioner is empowered to seek the enforcement of any lawful written order 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.

Renumbered from R.S. 22:1366 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1966, No. 214, § 1. Amended by Acts 2009, No. 317, § 1; Acts

2012, No. 271, § 1.

§ 2207. Writ of mandamus

Nothing contained in this Chapter 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 Chapter 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.

Renumbered from R.S. 22:1367 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1979, No. 256, § 1.

§ 2208. Administrative hearings

As provided in Chapter 13-B of Title 49 of the Louisiana Revised Statutes of 1950, R.S. 49:991 et seq., the division of administrative law shall conduct any hearings required by any provision of this Chapter.

Renumbered from R.S. 22:1368 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 933, § 1. Amended by Acts 2009, No. 317, § 1; Acts 2012, No. 271, § 1.

CHAPTER 13. PILOT PROGRAMS AND DATABASES

PART I. PILOT PROGRAMS

§ 2221. Pilot programs; Department of Insurance; establishment

The Louisiana Workforce Commission and the Department of Insurance, conjunctively, after consultation with the office of workers' compensation administration in the Louisiana Workforce Commission, 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. 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 Louisiana Workforce Commission 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 workers' 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 workers' 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.

Renumbered from R.S. 22:21 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 656, § 1. Amended by Acts 1997, No. 1097, § 1, eff. July 14, 1997; Acts 2012, No. 271, § 1.

§ 2222. Pilot program; certain provisions

A. The Louisiana Workforce Commission 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 Louisiana Workforce Commission 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 Louisiana Workforce Commission and the Department of Insurance, conjunctively, shall issue an interim report and a final report 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 in this Part. The Louisiana Workforce Commission 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.

Renumbered from R.S. 22:22 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 656, § 1. Amended by Acts 1997, No. 1097, § 1, eff. July 14, 1997; Acts 2012, No. 271, § 1.

§ 2223. 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. 22:2221 through 2222 and which shall meet criteria established conjunctively by the Louisiana Workforce Commission 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. 22:241 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 this Code for an employee and his dependents.

Renumbered from R.S. 22:23 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1993, No. 656, § 1. Amended by Acts 1997, No. 1097, § 1, eff. July 14, 1997; Acts 1997, No. 1097, § 1, eff. July 14, 1997; Acts 2012, No. 271, § 1.

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

PART II. UNINSURED MOTORIST IDENTIFICATION DATABASE

§ 2231. 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.

Renumbered from R.S. 22:25.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 790, § 1.

§ 2232. 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.

Renumbered from R.S. 22:25.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 790, § 1.

PART III. LOUISIANA BASIC HEALTH INSURANCE PILOT PROGRAM

§ 2241. 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. 22:2243 shall be referred to as LaChoice.

Renumbered from R.S. 22:244 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1999, No. 294, § 1. Amended by Acts 2004, No. 751, § 1.

§ 2242. 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. 22:2243 and 2244.

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 R.S. 22:984, and 1061 through 1079, as further provided in R.S. 22:2245.

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 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. 22:1201 through 1215. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Renumbered from R.S. 22:245 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1999, No. 294, § 1. Amended by Acts 2003, No. 424, § 1, eff. June 18, 2003; Acts 2004, No. 751, § 1; Acts 2004, No. 843, § 1; Acts 2009, No. 317, § 1.

§ 2243. 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 Subpart I of Part I of Chapter 2 of this Title, R.S. 22:241 et seq.

(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 R.S. 22:984, and 1061 through 1079.

(4) Benefit criteria that require participating health insurance issuers to offer group and individual health insurance as defined in R.S. 22:1061(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 R.S. 22:984, and 1061 through 1079.

(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.

Renumbered from R.S. 22:246 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1999, No. 294, § 1. Amended by Acts 2003, No. 424, § 1, eff. June 18, 2003; Acts 2004, No. 751, § 1; Acts 2012, No. 271, § 1.

§ 2244. 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 Subpart I of Part I of Chapter 2 of this Title, R.S. 22:241 et seq.

(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 R.S. 22:984, and 1061 through 1079.

(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. 22:993, 1000(D) and (E), and 1836 shall not apply to any Department of Health and Hospitals blanket insurance program.

Renumbered from R.S. 22:246.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 751, § 1. Amended by Acts 2012, No. 271, § 1.

§ 2245. 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. 22:1061(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.

Renumbered from R.S. 22:247 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1999, No. 294, § 1.

§ 2246. 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.

Renumbered from R.S. 22:248 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1999, No. 294, § 1.

§ 2247. 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.

Renumbered from R.S. 22:249 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 593, § 1.

PART IV. CENTRAL DATABASE ON LIFE INSURANCE POLICIES

§ 2261. 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. 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, if 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. 22:47(16)(a), are exempt from inclusion in the central database and shall not be subject to the

requirements of this Section.

Renumbered from R.S. 22:14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2003, No. 1224, § 1. Amended by Acts 2004, No. 838, § 1; Acts 2012, No. 271, § 1.

CHAPTER 14. JOINT LEGISLATIVE COMMITTEE ON INSURANCE [REPEALED]

§§ 2271 to 2277. Repealed by Acts 2009, No. 503, § 2

CHAPTER 15. LOUISIANA CITIZENS PROPERTY INSURANCE CORPORATION

PART I. LOUISIANA CITIZENS PROPERTY INSURANCE CORPORATION

§ 2291. 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 Chapter 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 Chapter 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 such 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.

Renumbered from R.S. 22:1430 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2012, No. 271, § 1.

§ 2292. Definitions

As used in this Part, 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 commissioner of insurance 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 commissioner of insurance:

(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.

(d) Business interruption insurance but only with respect to commercial properties on a monoline basis.

(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. 22:2294 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 Chapter.

(12) "Subject lines of business" means the following lines of business: fire, allied lines, homeowners' multiperil, the property insurance portion of commercial multiperil policies, and the business interruption insurance portion of commercial multiperil policies or such interruption insurance with respect to commercial properties on a monoline basis.

Renumbered from R.S. 22:1430.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2004, No. 106, § 1; Acts 2009, No. 239, § 1; Acts 2012, No. 271, § 1.

§ 2293. 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. 22:2298 and shall exercise its powers through a board of directors established under R.S. 22:2294.

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. 42:11 et seq. 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. 42:16 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 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 Chapter, 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 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 if 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.

Renumbered from R.S. 22:1430.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2012, No. 271, § 1.

§ 2294. 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) Six representatives appointed by the governor: one from a list of two nominees from the Louisiana Bankers Association; one from a list of two nominees from the Louisiana Home Builders Association; one from a list of two nominees from the Society of Louisiana Certified Public Accountants; one from a list of two nominees from the Louisiana District Attorneys Association; and the remaining two 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 Property Casualty Insurers Association of America, 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 largest domestic property insurer in the state.

(11) One member appointed by the commissioner from a list of three nominees from the Louisiana Chapter of the National Association of Insurance and Financial Advisors, or its successor.

B. The quorum necessary for transaction of business is hereby established as

eight members of the board in attendance.

C. The members of the board shall elect the chairman, who shall be confirmed by the Senate if the chairman is a designee of an elected official.

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.

E. The members of the board shall be confirmed by the Senate. No elected official who serves on the board will be confirmed by the Senate. Should any elected official designate a member who is not an elected official, that designee shall be confirmed by the Senate.

F. Any member of the board who misses three consecutive meetings shall be removed from the board.

G. Effective January 1, 2008, members appointed to the board by the governor and the commissioner of insurance shall serve the following staggered terms:

(1) The member appointed from the Louisiana Bankers Association shall serve for a term of four years.

(2) The member appointed from the Louisiana Home Builders Association shall serve for a term of two years.

(3) The member appointed from the Society of Louisiana Certified Public Accountants shall serve for a term of four years.

(4) The two members appointed at large shall each serve for a term of two years.

(5) The member appointed from the Property Casualty Insurers Association shall serve for a term of four years.

(6) The member appointed from the American Insurance Association shall serve for a term of two years.

(7) The member appointed from the largest domestic property insurer in the state shall serve for a term of four years.

(8) The member appointed from the Louisiana District Attorneys Association shall serve for a term of four years.

(9) The member appointed from the Professional Insurance Agents of Louisiana shall serve for a term of two years.

(10) The member appointed from the Independent Insurance Agents of Louisiana shall serve for a term of four years.

Renumbered from R.S. 22:1430.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2006, 1st Ex.Sess., No. 13, § 1, eff. Feb. 23, 2006; Acts 2007, No. 403, § 1; Acts 2012, No. 271, § 1; Acts 2013, No. 278, § 1.

§ 2295. 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.

Renumbered from R.S. 22:1430.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1.

§ 2296. 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 commissioner of insurance, 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 Chapter.

B. Such immunity from liability does not apply to:

(1) Any of the persons or entities listed in Subsection A of this Section 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 Chapter.

Renumbered from R.S. 22:1430.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2012, No. 271, § 1.

§ 2297. 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. 22:2298.

B. The governing board of the corporation shall, pursuant to the provisions of this Chapter 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) Borrow funds necessary to effect the purposes of this Chapter. 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.

(2) 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.

(3) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Chapter.

D. The corporation shall:

(1) Repealed by Acts 2010, No. 414, § 1, eff. June 21, 2010.

(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 fewer 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. 22:2291 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.

(6) Purchase adequate reinsurance on risks insured by the corporation and the plans, in an amount approved by the board annually, and in amounts that are actuarially justified. The board shall purchase reinsurance in an adequate amount so as to minimize the likelihood of an assessment being levied pursuant to R.S. 22:2307.

(7) Establish qualifications for and authorize qualified agents to have binding authority pursuant to R.S. 22:2313.

(8) Perform such other acts as are necessary or proper to effectuate the purpose of this Chapter.

E. The governing board of the corporation shall be prohibited from authorizing any rehabilitation, liquidation, or dissolution of the corporation, and no such rehabilitation, liquidation, or dissolution of the corporation shall take effect as long as the corporation has bonds or other financial obligations outstanding unless adequate protection and 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. In the event of any rehabilitation, liquidation, or 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.

F. (1) The governing board of the corporation may seek and accept federal funds from the United States Department of Housing and Urban Development under the Community Development Block Grant Program. Any such funds shall be used by the corporation only to pay any current or other obligations on bonds or other indebtedness issued by the corporation for the purpose of paying any cost and claims that arose due to losses caused by hurricanes in the year 2005. In the event the governing board of the corporation receives federal funds from the United States Department of Housing and Urban Development under the Community Development Block Grant Program, for those funds remaining after the bonds are paid off, satisfied, or defeased, the corporation shall credit such amounts on a pro rata basis to assessable insurers who were subject to an assessment as provided for pursuant to R.S. 22:2291 et seq., and who will thereafter return such amount to the insured.

(2) The governing board of the corporation shall report annually to the House Committee on Insurance and the Senate Committee on Insurance on its usage of any funds received pursuant to Paragraph (1) of this Subsection.

Renumbered from R.S. 22:1430.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2006, 1st Ex.Sess., No. 13, § 1, eff. Feb. 23, 2006; Acts 2006, 1st Ex.Sess., No. 19, § 1; Acts 2006, No. 787, § 1; Acts 2012, No. 271, § 1.

§ 2298. 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 commissioner 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 Chapter.

(2) The Louisiana Senate Committee on Insurance and the Louisiana House Committee on Insurance and the commissioner of insurance 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 commissioner of insurance 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. 22:2291, or to expand on the essential property insurance and subject lines of business as defined in R.S. 22:2292.

(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. Repealed by Acts 2006, 1st Ex.Sess., No. 13, § 2, eff. Feb. 23, 2006.

Renumbered from R.S. 22:1430.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2005, No. 217, § 1, eff. June 29, 2005.

§ 2299. 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 commissioner of insurance after review of annual statements, other reports and other statistics the commissioner shall deem necessary to provide the information herein required and which the commissioner 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. Repealed by Acts 2007, No. 235, § 2, eff. Jan. 1, 2008.

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.

Renumbered from R.S. 22:1430.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1.

§ 2300. 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 commissioner of insurance 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. Repealed by Acts 2007, No. 235, § 2, eff. Jan. 1, 2008.

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.

Renumbered from R.S. 22:1430.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1.

§ 2301. 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.

E. An assessable insured or the insurer of an assessable insured who, during the term of a policy of insurance upon which an emergency assessment or regular assessment is applied, cancels the policy of insurance, endorses the policy of insurance, or makes changes to the policy of insurance which result in an increase or decrease in the premium shall cause the emergency assessment or regular assessment to be adjusted such that the insured or insurer shall owe or be owed, as the case may be, payment in an amount computed on a pro rata basis for the term of the policy.

Renumbered from R.S. 22:1430.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2007, No. 235, § 1, eff. Jan. 1, 2008.

§ 2302. Eligibility; application

A. Any person having an insurable interest in insurable property and who has been denied coverage by one or more insurers authorized to write property insurance in this state 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 commissioner of insurance which clearly states that the corporation is an insurer of last resort. Every application form shall require that the applicant disclose each insurance carrier or carriers who denied property insurance coverage to the applicant.

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. Except for the failure of an applicant to show a previous denial of coverage

by another property insurance carrier as provided in Subsection A of this Section, if the corporation for any other 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 commissioner of insurance and, after reviewing the facts, he 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 commissioner of insurance may request and the corporation shall provide any information which the commissioner deems necessary to a determination concerning the reason for the denial or delay of the application.

E. The corporation shall include a disclosure statement with each application and policy which notifies the policyholder that he may obtain a list of insurance producers and insurance companies that may be able to write their insurance coverage in the private insurance market. This disclosure shall be on a separate page from the policy and shall be distinctly labeled in fourteen point or larger type size. The disclosure shall include a description of the specific method of accessing the Department of Insurance website including the website address. The disclosure shall also include a list, from the website of the Department of Insurance, of the insurance companies referenced in this Section.

F. The corporation shall be required to write business with properly licensed general agencies operated by insurance companies who write business through exclusive insurance producers.

Renumbered from R.S. 22:1430.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008; Acts 2008, No. 388, § 1, eff. June 21, 2008; Acts 2010, No. 1023, § 1; Acts 2012, No. 271, § 1.

§ 2303. 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, and shall exceed by at least ten percent the higher of (a) the actuarially justified rate or (b) the highest rates charged among assessable insurers that have a minimum of two percent of the total direct written premium in each respective parish for that line of business in the preceding year, or, with respect to personal lines property insurance, excluding wind and hail policies, only, (c) the highest rates charged among assessable insurers in each respective parish which in the preceding year increased by at least twenty-five additional personal lines property insurance policies, excluding wind and hail policies, in such parish, the total number of such policies in effect for the parish over the year before. Such rates shall include an appropriate catastrophe loading factor and may include rules for classification of risks insured hereunder and rate modifications hereof.

(2) The method used to determine the highest rates charged among assessable insurers that have a minimum of two percent of the total direct written premium in each parish and with respect to personal lines property insurance, excluding wind and hail policies, only, the highest rates charged among assessable insurers

in each respective parish which in the preceding year increased by at least twenty-five additional personal lines property insurance policies, excluding wind and hail policies, in such parish, the total number of such policies in effect for the parish over the year before 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. The chief executive officer of the corporation or his designee shall survey all insurers to make the determinations necessary to comply with this Section. All insurers shall submit to the chief executive officer of the corporation or his designee all information necessary for the corporation to comply with the provisions of this Section. All information received by the chief executive officer or his designee in response to the survey shall be considered proprietary, privileged, and confidential by the chief executive officer, all members of his staff, and all members of the board of the corporation. Such information shall be exempt from the public records law (R.S. 44:1 et seq.). However, all such information shall be subject to the legislative auditor's authority pursuant to R.S. 24:513 et seq. The chief executive officer of the corporation or his designee shall execute appropriate confidentiality agreements to protect the information provided by assessable insurers, making allowance for the information to be provided to the commissioner of insurance as part of the corporation's rate filing and to the legislative auditor as provided in this Paragraph.

(3) Prior to determining any such rates, the governing board shall adopt such formulas as may be necessary for determining the rates. The board may establish rating territories as it deems appropriate. Any changes to the rating territories shall be approved by House and Senate committees on insurance, acting jointly.

(4) When it is deemed necessary to implement a parish-wide average rate increase in excess of twenty-five percent on wind and hail insurance coverage in any single parish, the corporation shall notify the House and Senate committees on insurance. Upon such notification, a hearing may be requested by either committee chairman or by a majority of the membership of either committee. In the event of a request for a hearing, the House and Senate committees shall meet jointly. If a joint meeting of the committees is called, the chief executive officer and the staff or consulting actuary for the corporation shall provide testimony at the meeting which specifies, by parish, the basis and methodology used in determining the proposed rate increase.

B. In addition to the rates otherwise determined pursuant to this Section, including the premium tax provided for in R.S. 22:831, the corporation shall impose and collect an additional amount equal to the premium tax provided for in R.S. 22:831 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. 22:2291.

C. The corporation shall make a rate filing at least once a year for the plans, with the rates to be effective within twelve months of the previous rate filing's effective date. Nothing in this Section shall require or permit the corporation to adopt a rate that is inadequate or unfairly discriminatory under R.S. 22:1451 et seq. Subject to the provisions of Subsections A and B of this Section, the rates shall be approved by the commissioner of insurance.

D. (1) Notwithstanding the provisions of Paragraph (A)(1) of this Section, until August 15, 2010, the corporation shall charge the higher of (a) actuarially justified rates or (b) the highest rates charged among assessable insurers that have a minimum of two percent of the total direct written premium in each respective parish for that line of business in the preceding year, or, with respect to personal lines property insurance, excluding wind and hail policies, only, (c) the highest rates charged among assessable insurers in each respective parish which in the preceding year increased by at least twenty-five additional personal lines property insurance policies, excluding wind and hail policies, in such parish, the total number of such policies in effect for the parish over the year before, in any noncompetitive market unless competition resumes. If the corporation is writing more than fifty percent of the residential property insurance business in a market, including wind- and hail-only coverages, the board of directors shall report that fact to the commissioner of insurance. Notwithstanding any other provision of law to the contrary, until August 15, 2015, regardless of whether a competitive market may exist, the ten percent rate in excess of the higher of (a) the actuarially justified rate or (b) the highest rates charged among assessable insurers that have a minimum of two percent of the total direct written premium in each respective parish for that line of business in the preceding year, or, with respect to personal lines property insurance, excluding wind and hail policies, only, (c) the highest rates charged among assessable insurers in each respective parish which in the preceding year increased by at least twenty-five additional personal lines property insurance policies, excluding wind and hail policies, in such parish, the total number of such policies in effect for the parish over the year before, as authorized in Subsection A of this Section, shall not apply in St. Mary Parish and parishes listed in R.S. 40:1730.27(A).

(2) As used in this Subsection, the following definitions shall apply:

(a) "Market" means the interaction between buyers and sellers in the procurement of a line of insurance in any parish in the state pursuant to provisions in this Subsection.

(b) "Noncompetitive market" means a market subject to a ruling by the commissioner of insurance that a reasonable degree of competition does not exist.

(3) When the commissioner is informed that the corporation is writing more than fifty percent of the residential property insurance business in a market, the commissioner shall determine if a reasonable degree of competition exists within that market. Upon a finding that a competitive market does not exist, the commissioner shall inform the board of directors of the corporation.

(4) The board of directors of the corporation shall use the commissioner's findings in determining the application of its noncompetitive rating structure in the market that has been determined to be noncompetitive.

(5) The following factors shall be considered by the commissioner in determining if a reasonable degree of competition exists in a particular line of insurance:

(a) The number of insurers or groups of affiliate insurers providing coverage in the market.

(b) Measures of market concentration and changes of market concentration over time.

(c) Ease of entry into the market and the existence of financial or economic barriers preventing new insurers from entering the market.

(d) The extent to which any insurer or group of affiliated insurers controls all or a portion of the market.

(e) Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options.

(f) The availability of private insurance coverage to consumers in the market.

(g) The opportunities available to consumers in the market to acquire pricing and other consumer information.

(h) The number of residential property insurance policies written by the residual market.

Renumbered from R.S. 22:1430.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2005, No. 217, § 1, eff. June 29, 2005; Acts 2006, No. 787, § 1; Acts 2007, No. 420, § 1; Acts 2008, No. 211, § 1; Acts 2008, No. 347, § 1; Acts 2009, No. 483, § 1; Acts 2012, No. 632, § 1; Acts 2013, No. 278, § 1.

§ 2304. 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 commissioner of insurance. 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.

Renumbered from R.S. 22:1430.13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1.

§ 2305. Annual and quarterly reports

A. The corporation shall file with the commissioner of insurance annual and quarterly statements as required for authorized insurers pursuant to R.S. 22:571 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 commissioner of insurance 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 commissioner.

Renumbered from R.S. 22:1430.14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009.

Acts 2003, No. 1133, § 1. Amended by Acts 2004, No. 46, § 1, eff. May 21, 2004; Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 2306. 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. 22:1981 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.

Renumbered from R.S. 22:1430.15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1.

§ 2307. 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. 22:2299 and 2300. 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 commissioner of insurance at least thirty days in advance of the commencement of such a charge.

G. The corporation may pledge, assign, and grant a security interest in the 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, including without limitation lines of credit or other financing mechanisms issued or created under this Subsection pursuant to the procedures of Chapter 13 of Title 39 of the Louisiana Revised Statutes of 1950, R.S. 39:1421 et seq., 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 and use such funds to pay any current or other obligations on the bonds or other indebtedness even if no event of default has occurred under the bonds or other indebtedness. 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 to be levied and collected and shall be used to make any payments due with respect to any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remains outstanding, even if no event of default has occurred under the bonds or other indebtedness, unless adequate protection and 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 commissioner of insurance 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.

Renumbered from R.S. 22:1430.16 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2006, 1st Ex.Sess., No. 13, § 1, eff. Feb. 23, 2006; Acts 2012, No. 271, § 1.

§ 2308. 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. 22:2303(B), 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.

Renumbered from R.S. 22:1430.17 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 2003, No. 1133, § 1. Amended by Acts 2012, No. 271, § 1.

§ 2309. Operation of the Coastal and FAIR Plans; requirements

The governing board of the corporation shall provide property insurance pursuant to this Chapter which shall include any property easily accessible by road for emergency vehicles.

Renumbered from R.S. 22:1430.18 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 665, § 1.

§ 2310. Prohibition against impairment of obligations

A. The state and any public instrumentality thereof and the Louisiana Legislature covenants and agrees with the corporation and the holders of the bonds that, as long as bonds or other indebtedness of the corporation remain outstanding, the state and any public instrumentality thereof and the Louisiana Legislature will not in any way impair the rights and remedies of such holders or the security for such bonds or other indebtedness and any public instrumentality thereof and the Louisiana Legislature, together with interest thereon as well as all costs and expenses in connection with any action or proceeding by or on behalf of such holders until all such bonds are fully paid and discharged.

B. The provisions of R.S. 12:202.1 shall not apply to the Louisiana Citizens Property Insurance Corporation.

Renumbered from R.S. 22:1430.19 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 13, § 1, eff. Feb. 23, 2006.

§ 2311. Limitation on bankruptcy

A. Prior to the date that is two years and one day after which the corporation no longer has any bonds outstanding, the corporation is prohibited from filing and shall have no authority to file a voluntary petition under the Federal Bankruptcy Code as it may, from time to time, be in effect, and neither any public official nor any organization, entity or other person shall authorize the corporation to be or to become a debtor under the Federal Bankruptcy Code during such period. The provisions of this Section shall be part of any contractual obligation owed to the holders of bonds issued under this Subpart. Any such contractual obligation shall not subsequently be modified by state law during the period of the contractual obligation, and the state of Louisiana and any public instrumentality thereof and the Louisiana Legislature hereby covenants with the holders that the state and any public instrumentality thereof and the Louisiana Legislature shall not limit or alter the denial of authority under this Section during the period referred to in this Subsection.

B. For purposes of this Section, the corporation is deemed to be an instrumentality of the state and subject to the provisions of R.S. 13:4741 and R.S. 39:619 through 622 and shall not be subject to the provisions of R.S. 22:73, 96, 731 through 737, and 2001 through 2044.

Renumbered from R.S. 22:1430.20 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 13, § 1, eff. Feb. 23, 2006.

§ 2312. Severability

The provisions of this Chapter are severable. If any provision or item of this Chapter, or application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of this Chapter which are to be given effect without the invalid provision, item or application of the Chapter.

Renumbered from R.S. 22:2312 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 13, § 1, eff. Feb. 23, 2006.

§ 2313. Producers; authority to bind coverage

A. Every producer licensed to sell property and casualty insurance may sell insurance policies which are issued by the Louisiana Citizens Property Insurance Corporation through its FAIR and Coastal Plans.

B. The governing board shall formulate criteria and an application process to certify qualified licensed property and casualty insurance producers to bind insurance coverage for the FAIR and Coastal Plans. In order to be qualified for binding authority, the producer shall have adequate errors and omission insurance and complete a training course offered by the Louisiana Citizens Property Insurance Corporation. Pursuant to the Administrative Procedure Act, R.S. 49:950 et seq., the governing board shall promulgate rules which set forth standards by which a producer is deemed qualified for binding authority.

C. The governing board may withdraw binding authority granted to any producer certified pursuant to Subsection B of this Section if that producer fails to follow written guidelines for underwriting as required by the corporation.

Renumbered from R.S. 22:1430.22 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, No. 787, § 1. Amended by Acts 2012, No. 271, § 1.

§ 2314. Policy take-out program

A. The legislature created the Louisiana Citizens Property Insurance Corporation to operate insurance plans as a residual market for residential and commercial property. The legislature further intends that the corporation work toward the ultimate depopulation of these residual market plans. To encourage the ultimate depopulation of these residual market plans, there is hereby created the Louisiana Citizens Property Insurance Corporation Policy Take-Out Program.

B. (1) Not less than once per calendar year, the corporation shall offer all of its in-force policies for removal to the voluntary market. The corporation shall include offers for depopulation policies with all available geographic and risk characteristics that serve to reduce the exposure of the corporation.

(2) Each insurer participating in the take-out program shall be offered all of the corporation's in-force policies. In response, the insurers shall provide the corporation with a list of policies they propose to take out subject to authorization by the policy's agent of record. No policy shall be assumed by a take-out company without the authorization of the agent of record.

C. Each insurer admitted to write homeowners insurance or insurance insuring

one- or two-family owner occupied premises for fire and allied lines or insurance which covers commercial structures in the state of Louisiana may apply to the Louisiana Citizens Property Insurance Corporation to become a take-out company. Insurers will be approved to participate in the depopulation of the Louisiana Citizens Property Insurance Corporation based on the following criteria:

(1) The capacity of the insurer to absorb the policies proposed to be taken out of the corporation and the concentration of risks of those policies. Such capacity may be evidenced by providing to the Louisiana Citizens Property Insurance Corporation a copy of a valid certificate of authority issued by the Department of Insurance to the insurer. An insurer shall not be qualified to participate in the take-out program unless that insurer has at least a B+ rating with A.M. Best, or its equivalent.

(2) An insurer shall have the rates proposed to be charged for the policies being taken out, filed, and approved by the Department of Insurance with an effective date prior to the assumption of policies. The insurer shall provide proof to Louisiana Citizens Property Insurance Corporation that the rates have been approved and are adequate under R.S. 22:1451 et seq.

(3) The rates which are charged by the company submitting a take-out plan must comply with R.S. 22:2303 in the first year that the company charges premiums to the customer. During the second and third years of coverage, the take-out company shall apply to the Department of Insurance for rates which are actuarially justified, but in no case may the rates be greater than those authorized in R.S. 22:2303.

D. The corporation shall submit an insurer's application to participate to the governing board for approval.

E. The board of directors of the Louisiana Citizens Property Insurance Corporation shall develop guidelines for the take-out program which shall be filed with and approved by the Senate Committee on Insurance, the House Committee on Insurance, and the commissioner of insurance.

F. The provisions of this Section shall not be construed to impair the right of any Louisiana Citizens Property Insurance Corporation policyholder, upon receipt of an approved take-out offer, to retain his current producer, so long as that producer is a licensed insurance producer authorized to bind insurance coverage for the FAIR and Coastal Plans, or to retain Louisiana Citizens Property Insurance Corporation as their insurer. This right shall not be canceled, suspended, impeded, abridged, or otherwise compromised by any rule, plan of operation, or depopulation plan.

Renumbered from R.S. 22:1430.23 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 377, § 1, eff. Nov. 1, 2007. Amended by Acts 2008, No. 465, § 1; Acts 2010, No. 397, § 1, eff. June 21, 2010; Acts 2012, No. 271, § 1; Acts 2014, No. 114, § 1.

§ 2315. Adjusters

A. With respect to contracting with adjusters to adjust claims, the corporation shall give preference to adjusters and businesses engaged in the business of adjusting claims, who have been domiciled in Louisiana for a period of not less

than two years, if the adjusting of such claims is subject to a fee schedule or other fixed fee arrangement. For purposes of reciprocal preference, the provisions of this Section shall apply only to the Louisiana Citizens Property Insurance Corporation.

B. Each service provider for the Louisiana Citizens Property Insurance Corporation shall provide monthly reports to the corporation that include the names of the adjusting companies domiciled in Louisiana for two years whose services are being used as well as the number of claims provided to these companies.

Renumbered from R.S. 22:1430.24 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 468, § 1. Amended by Acts 2008, No. 434, § 1, eff. June 25, 2008; Acts 2012, No. 271, § 1.

Validity—Acts 2007, No. 468

Due to the absence of duly adopted amendments in the enrolled version of Senate Bill No. 183 (enacted as Acts 2007, No. 468), as presented to and signed by the governor, the enacted provisions may be constitutionally infirm.

§ 2316. Underwriting

With respect to contracting with service providers to underwrite insurance policies, the corporation shall give preference to service providers and businesses engaged in the business of underwriting insurance policies, who have underwriters domiciled in Louisiana for a period of not less than two years, if the underwriting of such policies is subject to a fee schedule or other fixed fee arrangement. For purposes of reciprocal preference, the provisions of this Section shall apply only to the Louisiana Citizens Property Insurance Corporation.

Renumbered from R.S. 22:1430.25 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 434, § 2, eff. June 25, 2008. Amended by Acts 2012, No. 271, § 1.

§ 2317. Refund of certain assessments

At the time of issuance or annual renewal of a property insurance policy, each insurer shall include the following with the policy sent to each insured:

(1) Information on the electronic link to the form designated by the Department of Revenue to receive a refund from the state after its payment by the insured pursuant to R.S. 47:6025(A)(3) for the amount of any surcharge, market equalization charge, or other assessment levied by the corporation pursuant to R.S. 22:2307 due to Hurricanes Katrina and Rita.

(2) A statement in fourteen-point or boldface type that any surcharge, market equalization charge, or other assessment levied by the corporation pursuant to R.S. 22:2307 due to Hurricanes Katrina and Rita is refundable.

Added by Acts 2010, No. 345, § 1.

PART II. FAIR AND COASTAL PLANS

§ 2321. Declaration and purpose

A. Louisiana Insurance Underwriting Plan (Coastal Plan) and Louisiana Joint Reinsurance Plan (FAIR Plan) were re-created and continued by Act 1133 of the 2003 Regular Session of the Louisiana Legislature, now R.S. 22:2291 et seq. That Act, which became effective on August 15, 2003, also created Louisiana Citizens Property Insurance Corporation, and provided that Coastal Plan and FAIR Plan, as successors respectively to the programs established by Act 35 of the 1970 Regular Session of the Louisiana Legislature, and by Act 424 of the 1992 Regular Session of the Louisiana Legislature, shall be available as insurance programs of Louisiana Citizens Property Incorporation beginning January 1, 2004.

B. The Legislature of Louisiana hereby declares that in enacting Act 1133 of the 2003 Regular Session of the Louisiana Legislature, its purpose and intent was, notwithstanding the repeal of R.S. 22:1406.1 through 1406.13 and 1431 through 1445, that from and after August 15, 2003, the effective date of the Act, and through and including December 31, 2003, Louisiana Insurance Underwriting Plan (Coastal Plan) and Louisiana Joint Reinsurance Plan (FAIR Plan) should continue to provide an adequate market for fire insurance with extended coverage and vandalism and malicious mischief and homeowners' coverages as residual market insurance plans pursuant to their respective plan documents setting forth their rules of operation, approved and on file with the commissioner of insurance, and that Louisiana Insurance Underwriting Plan (Coastal Plan) and Louisiana Joint Reinsurance Plan (FAIR Plan) should continue to service those policies issued by them on and prior to December 31, 2003, until all such policies have expired and all claims arising thereunder have been resolved. Because Act 1133 of the 2003 Regular Session of the Louisiana Legislature repealed R.S. 22:1406.1 through 1406.13, and 1431 through 1445, remedial and curative legislation is needed to make statutory provision for the governance and administration of the Louisiana Insurance Underwriting Plan (Coastal Plan) and Louisiana Joint Reinsurance Plan (FAIR Plan), from and after August 15, 2003, and the servicing of residual market property insurance policies issued by the plans on and before December 31, 2003, including servicing of claims arising thereunder and to recognize and declare that those policies issued by Louisiana Insurance Underwriting Plan (Coastal Plan) and Louisiana Joint Reinsurance Plan (FAIR Plan) having inception dates of August 15, 2003, through and including December 31, 2003, are lawful responses to the intent and purposes of the legislature as set forth herein, in former R.S. 22:1431 through 1445, and in Act 1133 of the 2003 Regular Session of the Louisiana Legislature.

C. The legislature further declares that this statute is curative and remedial, is to have retrospective effects to August 15, 2003, should be given broad and liberal interpretation and construction in order to carry out its purposes and intent, and should not be construed as repealing, amending, or modifying Act 1133 of the 2003 Regular Session of the Louisiana Legislature, or the mandate and authority of Louisiana Citizens Property Insurance Corporation to issue or cause to be issued FAIR Plan or Coastal Plan policies beginning January 1, 2004, as programs of Louisiana Citizens Property Insurance Corporation.

Renumbered from R.S. 22:1441 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2322. Louisiana Insurance Underwriting Plan (Coastal Plan); definitions

As used in R.S. 22:2322 through 2334, unless the context otherwise requires:

(1) "Coastal area" means all of that area of the state designated in the "plan" approved by the commissioner of insurance.

(2) "Essential property insurance" means any of the following coverages against direct loss to property as defined by the plan approved by the commissioner of insurance:

(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. 22:2325 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. 22:2321 through 2335. 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. 22:2321 through 2335. 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 allied lines 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 commissioner of insurance relative to the Louisiana Insurance Underwriting Plan.

Renumbered from R.S. 22:1441.1 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004. Amended by Acts 2009, No. 326, § 1, eff. Jan. 1, 2010.

§ 2323. 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.

Renumbered from R.S. 22:1441.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2324. 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.

Renumbered from R.S. 22:1441.3 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2325. 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.

Renumbered from R.S. 22:1441.4 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2326. 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 commissioner of insurance after review of annual statements, other reports and other statistics the commissioner shall deem necessary to provide the information required in this Section and which the

commissioner 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 commissioner of insurance, 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 Louisiana 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.

Renumbered from R.S. 22:1441.5 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004. Amended by Acts 2012, No. 271, § 1.

§ 2327. 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 commissioner of insurance, 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 commissioner of insurance to carry out the purposes of this Part.

B. The governing committee of the plan may, subject to the approval of the commissioner of insurance, amend the plan at any time. The commissioner may review the plan at any time he deems expedient or prudent, but not less than once

in each calendar year. After review of the plan the commissioner 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.

Renumbered from R.S. 22:1441.6 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2328. 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 commissioner of insurance, 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. 22:2322(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 commissioner of insurance and, after reviewing the facts, he 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 commissioner of insurance may request and the governing committee of the plan shall provide any information the commissioner deems necessary to a determination concerning the reasons for the denial or delay of the application.

Renumbered from R.S. 22:1441.7 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 2329. 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.

Renumbered from R.S. 22:1441.8 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2330. 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 commissioner of insurance; however, such rates may include rules for classification of risks insured hereunder and rate modifications thereof.

Renumbered from R.S. 22:1441.9 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2331. Appeal to the commissioner; appeal to the court from the commissioner

Any person insured pursuant to R.S. 22:2322 through 2334 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 commissioner of insurance. Any hearings held by the commissioner of insurance pursuant to such an appeal shall be in accordance with the procedure set forth in the insurance laws of Louisiana. All persons or insureds aggrieved by any order or decision of the commissioner of insurance may appeal as is provided by the provisions of the insurance laws of the state of Louisiana.

Renumbered from R.S. 22:1441.10 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 2332. 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 commissioner of insurance. 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.

Renumbered from R.S. 22:1441.11 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2333. Immunity from liability

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 any of his 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.

Renumbered from R.S. 22:1441.12 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2334. Annual report

The governing committee of the plan or its designee shall file in the office of the commissioner of insurance 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 commissioner and shall be in such form as is required by him. The commissioner may at any time require the governing committee of the plan to furnish to him any additional information with respect to its transactions or any other matter which the commissioner deems to be material to assist him in evaluating the operation and experience of the plan.

Renumbered from R.S. 22:1441.13 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2335. 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.

Renumbered from R.S. 22:1441.14 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2336. Louisiana Joint Reinsurance Plan (FAIR Plan); definitions

As used in R.S. 22:2336 through 2347, unless the context otherwise requires:

(1) "Designated area" means all of that area of the state designated in the plan on file with the commissioner of insurance 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 commissioner of insurance:

(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. 22:2338 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 allied lines 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 commissioner of insurance relative to the Louisiana Joint Reinsurance Plan.

Renumbered from R.S. 22:1441.15 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004. Amended by Acts 2009, No. 326, § 1, eff. Jan. 1, 2010.

§ 2337. Louisiana Joint Reinsurance Plan; immunity from liability; commissioner of insurance

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 commissioner of insurance is hereby authorized to issue rules and regulations for the purpose of carrying out the provisions of R.S. 22:2336 through 2347.

C. 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 any of his 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. 22:2336 through 2347.

Renumbered from R.S. 22:1441.16 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2338. 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.

Renumbered from R.S. 22:1441.17 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2339. 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.

Renumbered from R.S. 22:1441.18 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2340. 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 commissioner of insurance 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.

Renumbered from R.S. 22:1441.19 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2341. Plan

A. (1) The plan as filed and approved by the commissioner of insurance 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. 22:2336 through 2347.

(2) The plan shall be filed with the commissioner of insurance and the

commissioner may, in his discretion, consult with the governing committee of the plan and may seek any further information which he deems necessary for a decision.

B. The governing committee of the plan may, subject to the approval of the commissioner of insurance, amend the plan at any time. The commissioner may review the plan at any time he deems prudent, but not less than once in each calendar year. After review of the plan, the commissioner may amend it after consultation with the governing committee of the plan, and upon certification to the governing committee of such amendment.

Renumbered from R.S. 22:1441.20 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2342. 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 commissioner 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 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 commissioner of insurance, and the commissioner, 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 his duties pursuant to this Section, the commissioner of insurance may request and the governing committee of the plan shall provide any information which the commissioner deems necessary to a determination concerning the reason for the denial or delay of the application.

Renumbered from R.S. 22:1441.21 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004. Amended by Acts 2007, No. 459, § 1, eff. Jan. 1, 2008.

§ 2343. 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.

Renumbered from R.S. 22:1441.22 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2344. Rates, rating plans, and rate rules applicable

Rates shall be in accordance with the rating plans approved by the commissioner of insurance 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.

Renumbered from R.S. 22:1441.23 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2345. 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 commissioner of insurance. 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.

Renumbered from R.S. 22:1441.24 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2346. Annual report

The governing committee of the plan shall file in the office of the commissioner of insurance each year a statement which shall summarize the transactions, conditions, operations, and affairs of the plan during the preceding fiscal year ending September thirtieth.

Renumbered from R.S. 22:1441.25 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

§ 2347. 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.

Renumbered from R.S. 22:1441.26 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2004, No. 761, § 1, eff. July 6, 2004.

CHAPTER 16. INSURE LOUISIANA INCENTIVE PROGRAM

PART I. INSURE LOUISIANA INCENTIVE PROGRAM

Former Chapter Heading

Acts 2007, No. 447, § 1 enacted former Chapter 10 of Title 22 without a heading. Pursuant to the statutory revision authority of the Louisiana State Law Institute, the former Chapter 10 heading was provided.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this Chapter) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2361. Short title

This Chapter shall be known as the "Insure Louisiana Incentive Program", hereinafter referred to as the "program".

Renumbered from R.S. 22:3301 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State

Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2362. Purposes; public purpose

A. Louisiana currently is experiencing a crisis in the availability and affordability of insurance for residential and commercial properties. Louisiana property owners and their insurers sustained catastrophic losses in 2005 from Hurricanes Katrina and Rita. As the result of their losses and their assessment of the risk of loss from future storms, many insurers have substantially reduced their participation in the voluntary market for residential and commercial property insurance. With fewer insurers in the voluntary market, competitive pressure on premium rates is reduced. Current underwriting practices have resulted in a substantial increase in the number of Louisiana property owners forced to obtain their property insurance coverage or their coverage for the wind peril from Louisiana Citizens Property Insurance Corporation (Citizens), the state insurer of last resort. As a result of the 2005 storms, Citizens has a substantial deficit that currently is and must be funded by assessments against insurers and policyholders. The decline in the voluntary insurance market substantially increases Citizens' exposure, thereby threatening to worsen its financial condition. Increased premiums and assessments make property insurance coverage unaffordable for some property owners, forcing them to sell or abandon their residential or commercial properties or preventing them from restoring storm-damaged properties, causing some residents to leave or fail to return to the state. The availability of property insurance at reasonable cost is essential to the economy of the state. Owners cannot invest in and lenders will not finance the construction and ownership of residential and commercial buildings without adequate property insurance protection. The state has a vital interest in fostering the availability of property insurance at reasonable cost.

B. The Insure Louisiana Incentive Program is adopted for the purpose of cooperative economic development and stability in Louisiana by encouraging

additional insurers to participate in the voluntary property insurance market in order to substantially increase the availability of property insurance, to substantially increase competitive pressure on insurance rates, and to substantially reduce the volume of business written by the Louisiana Citizens Property Insurance Corporation, thereby offering a less expensive alternative to its policyholders and reducing Citizens' exposure to an increased deficit and future assessments.

C. It is hereby declared by the legislature that assuring an adequate and affordable market for insurance for both residential and commercial properties in this state is essential to the economic viability of the state and its citizens, the assurance of an adequate and stable tax base for the state and its political subdivisions, and the health, welfare, and safety of its citizens. Accordingly, the establishment of the Insure Louisiana Incentive Program implemented through public-private partnerships is declared and demonstrated to be an essential public function and public purpose.

Renumbered from R.S. 22:3302 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2363. Cooperative endeavors; grants; regulations

A. The commissioner of insurance is authorized to implement the essential public purpose of this Chapter through public-private partnerships executed through cooperative endeavors with authorized insurers. Such endeavors may include matching capital fund grants under the provisions of this Chapter.

B. The commissioner of insurance may grant matching capital funds to qualified property insurers in accordance with the requirements of this Chapter from the fund. The commissioner shall adopt and promulgate rules and regulations in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., governing the application process and award of grants, use of grant funds, reporting requirements and other regulations to assure compliance with and to carry out the purposes of the program.

Renumbered from R.S. 22:3303 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007. Amended by Acts 2012, No. 271, § 1.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2364. Implementation; grant limitations

A. The commissioner of insurance shall adopt and promulgate rules and regulations to implement this program as soon as possible and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

B. When the program is ready for implementation, the commissioner shall issue a public invitation to insurers to submit grant applications. In the initial applications, the commissioner shall not allocate individual grants less than two million dollars nor in excess of ten million dollars. In the initial allocation of grants only, the commissioner shall allocate twenty percent of the total amount of funds available for grants to domestic insurers.

C. In the event that all monies in the fund are not allocated in response to the first invitation for grant applications, then the commissioner shall issue a second invitation for grant applications. In the second invitation, the commissioner shall not allocate individual grants less than two million dollars nor in excess of ten million dollars, but insurers who have been allocated a grant in response to the first invitation may apply for an additional grant up to the ten million dollar limit. In the event that all monies in the fund are not allocated in response to the second invitation for grant applications, then the commissioner shall issue a third invitation for grant applications. In the third invitation, the commissioner shall not allocate individual grants less than two million dollars nor in excess of ten million dollars, but insurers who have been allocated a grant in response to the first or second invitation may apply for an additional grant up to the ten million dollar limit.

D. Once the commissioner has finalized all responses from three separate invitations for grant applications authorized under this Chapter, any unexpended and unencumbered monies in the fund and any matching capital fund grant funds that are not earned pursuant to R.S. 22:2370(A) shall be used pursuant to the provisions of R.S. 22:2372. However, if less than thirty-five million dollars remains in the Insure Louisiana Incentive Fund after responses have been finalized to the three separate invitations for grant applications, then the remaining monies in the fund shall instead be used to accelerate payoff of the Unfunded Accrued Liability of the state retirement systems.

E. The total amount of funds available for this program is the amount appropriated or otherwise made available to the fund by the legislature. If the amount requested in grant applications exceeds the amount of funds available, the commissioner of insurance shall have the discretion to prioritize and allocate funds among insurers deemed eligible to participate in the program, considering the financial strength of each insurer and the potential for its business plan to improve the availability and affordability of property insurance in Louisiana.

F. Prior to the award of any grant pursuant to the provisions of this Chapter, such grant shall be subject to the review and approval of the Joint Legislative Committee on the Budget. The use of grant funds and unexpended and unencumbered monies pursuant to the provisions of Subsection D of this Section shall not be subject to review and approval of the Joint Legislative Committee on the Budget.

Renumbered from R.S. 22:3304 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007. Amended by Acts 2008, No.

390, § 1, eff. June 21, 2008; Acts 2008, No. 469, § 1; Acts 2012, No. 271, § 1.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2365. Minimum capital requirements

A. Grants shall be made only to insurers who satisfy minimum capital requirements as specified in the rules and regulations adopted and promulgated by the commissioner of insurance, which shall include capital and surplus exceeding twenty-five million dollars, stable financial condition as shown by a satisfactory risk-based capital level, and an adequate risk-based reinsurance program.

B. In no event shall matching fund grants exceed twenty percent of an insurer's capital and surplus.

Renumbered from R.S. 22:3305 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2366. Satisfactory prior experience

As determined by the commissioner of insurance, grants shall be made only to insurers with satisfactory prior experience in writing property insurance or to new insurers whose management has satisfactory prior experience in property insurance.

Renumbered from R.S. 22:3306 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State

Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2367. Authorized insurers

Although a non-admitted insurer, including an approved unauthorized insurer, may apply for a grant, the insurer must become admitted and licensed to do business in Louisiana before it may actually receive the grant funding. The commissioner of insurance may reallocate funds allocated to such non-admitted insurer if that insurer does not apply on a timely basis, as specified in the regulations, or is not approved as an admitted and licensed insurer.

Renumbered from R.S. 22:3307 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the

National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2368. Matching capital fund grants

A. The insurer shall make a commitment of capital of not less than two million dollars to write property insurance in Louisiana that complies with the requirements of R.S. 22:2369.

B. Matching capital fund grants authorized under this Chapter shall match such newly allocated insurer capital funds at a ratio of one dollar of state capital grant funds to one dollar of allocated insurer capital funds.

Renumbered from R.S. 22:3308 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured

and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2369. Net written premium requirements

A. "Net written premiums" means the total premiums, exclusive of assessments and other charges, paid by policyholders to insurers for policies that comply with this Section, minus any return premiums or other premium credits due policyholders.

B. To comply with the requirements of this Chapter, the new property insurance written by the insurer who received a matching capital fund grant shall be residential, commercial, mono-line, or package property insurance policies in Louisiana, and must include coverage for wind and hail with limits equal to the limits provided for other perils insured under such policies. The net written premium requirements of this Section will be satisfied only by property insurance coverages reported on the Annual Statement State Page filed with the Department of Insurance under lines 1 (Fire), 2.1 (Allied Lines), 3 (Farmowners), 4 (Homeowners), or 5.1 (Commercial Multi-peril Non-liability).

C. Insurers who receive the matching capital fund grants must write property insurance in Louisiana that complies with the requirements of this Section with net written premiums of at least a ratio of two dollars of premium for each dollar of the total of newly allocated insurer capital and the matching capital fund grant. Thus, if the insurer allocates two million dollars in capital and receives a matching capital fund grant of two million dollars, the insurer must write property insurance in Louisiana with net written premiums of at least eight million dollars.

D. In the first twenty-four months after receipt of matching capital fund grants, insurers shall write at least fifty percent of the net written premium for policyholders whose property is located in the parishes included in the federal Gulf Opportunity Zone Act of 2005 [1] in Louisiana. Twenty-five percent of the net written premium for policyholders whose property was formerly insured by the Louisiana Citizens Property Insurance Corporation, and at least fifty percent of such policyholders shall have property located in the parishes included in the federal Gulf Opportunity Zone Act of 2005 in Louisiana. Insurers must maintain this net written premium ratio over five years to fully earn the matching capital fund grant as outlined in R.S. 22:2370.

E. (1) The commissioner shall promulgate rules pursuant to the Administrative Procedure Act, R.S. 49:950 et seq., to establish procedures to monitor the net written premium of insurers receiving any grant under this Chapter to ensure that the insurer is in compliance with the provisions of this Section. These rules shall include provisions for the return of grant money to the state, on a pro

rata basis, for failure to meet the requirements of this Section. Notwithstanding the provisions of R.S. 22:2370 to the contrary, the commissioner shall seek the return of unearned grant money from any insurer who has not been in compliance with this Section for five consecutive years commencing on January 1, 2009, and ending on December 31, 2013.

(2)(a) Notwithstanding the provisions of this Chapter to the contrary, rules and regulations promulgated by the commissioner pursuant to this Chapter shall provide that grants, made pursuant to a third invitation for grant applications, may be made to insurers providing coverage against damage to an existing dwelling. The grant shall be made only as to those policies transferred from an existing dwelling to a new dwelling provided the risk of catastrophe associated with the new dwelling is the same as or no greater than the level of risk of catastrophe associated with the existing dwelling.

(b) Grants shall also be made under this Paragraph to any insurer that was forced to reduce coverage, or drop coverage entirely, on existing dwellings in order that the insurer maintain its financial stability or solvency. Such grant shall be contingent on the insurer reinstating such former coverage or better coverage on the existing dwellings.

Renumbered from R.S. 22:3309 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007; Acts 2007, No. 447, § 1, eff. Dec. 1, 2007. Amended by Acts 2008, No. 390, § 1, eff. June 21, 2008; Acts 2012, No. 271, § 1.

[1] 26 U.S.C.A. § 1400M et seq.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers."

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a

thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2370. Earned capital

A. An insurer who has received a matching capital fund grant under the provisions of this Chapter is entitled to earn the grant at the rate of twenty percent per year for each year in which the insurer maintains the net written premiums in compliance with the requirements of this Chapter, so that the insurer can earn the entire grant in five years.

B. If any insurer fails to comply with the requirements of this Chapter at the end of any year of the grant, the commissioner of insurance shall have the option of granting an extension if the insurer shows promise of future compliance.

C. If the commissioner of insurance finds that an insurer has failed to comply with the statutory or regulatory requirements for the grant, the commissioner may declare the insurer in default. The insurer in default shall repay any matching capital fund grant funds that have not been earned under Subsection A of this Section, plus legal interest from the date of the commissioner's default declaration.

D. In the event of insolvency of an insurer, the obligation to repay matching capital fund grants shall not be a liability of the Louisiana Insurance Guaranty Association.

Renumbered from R.S. 22:3310 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2007, No. 447, § 1, eff. July 11, 2007.

Louisiana State Catastrophe Fund—Acts 2007, No. 447

Section 6 of Acts 2007, No. 447 (§ 1 of which enacted this section) provides:

"Section 6. Upon the enactment of federal law providing for the creation of a National Catastrophe Reinsurance Fund (hereinafter referred to as the 'National Fund') that provides a financial backstop to state catastrophe funds designed to provide national reinsurance to state catastrophe funds, the legislature may authorize, by specific legislation, the creation of the Louisiana State Catastrophe Fund (hereinafter referred to as the 'Fund') established in the State Treasury as a special fund to be structured and operated consistent with model legislation adopted by the National Conference of State Legislators for this purpose. The Fund shall provide reinsurance and shall include specific provisions to enhance prevention and mitigation measures, strengthen first responders, improve recovery and rebuilding processes, and educate homeowners and other property owners on issues surrounding catastrophe management. The Fund may be created as soon as practicable to qualify for participation in the National Fund and to provide premium savings to consumers.

"The Fund may be created to operate on a tax-exempt and nonprofit basis to maximize savings for consumers and to make private insurance more available and affordable for consumers of homeowners insurance in the state of Louisiana. All savings shall be passed on to the consumers. The Fund shall also be structured and operated to attract new carriers and capacity to the state and to make the market more competitive, stable and financially strong. The Fund shall require that all insurers writing covered policies of homeowners insurance to conduct a thorough actuarial review of their homeowners insurance rates associated with catastrophe coverage for the perils covered by the Fund consistent with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Insurance Ratemaking and shall adjust their rates to take into account all reinsurance expense savings and all reductions in loss costs due to the Fund. The Fund shall also provide for mandatory participation with minimum retention levels by insurers; determine reinsurance premiums on an actuarially indicated basis to prevent regional subsidization."

§ 2371. Repealed by Acts 2009, No. 226, § 3, eff. July 1, 2009

§ 2372. Repealed by Acts 2009, No. 404, § 1, eff. July 7, 2009

CHAPTER 17. INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

§ 2381. Interstate Insurance Product Regulation Compact; Louisiana's participation

The Interstate Insurance Product Regulation Compact, the full text of which is set forth and confirmed by the Louisiana Legislature, is hereby entered into on behalf of the state of Louisiana. The compact shall become effective when enacted into law by at least two states. The full text of said compact is as follows:

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

ARTICLE I. PURPOSES

The purposes of this Interstate Insurance Product Regulation Compact are, through means of joint and cooperative action among the Compacting States:

(1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

(2) To develop uniform standards for insurance products covered under the Compact;

(3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

(4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

(5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

(6) To create the Interstate Insurance Product Regulation Commission; and

(7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II. DEFINITIONS

For purposes of this Compact:

(1) "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

(2) "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

(3) "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section (1), or been terminated pursuant to Article XIV, Section (2).

(4) "Commission" means the Interstate Insurance Product Regulation Commission established by this Compact.

(5) "Commissioner" means the chief insurance regulatory official of a State including, but not limited to, commissioner, superintendent, director or administrator.

(6) "Domiciliary State" means the state in which an Insurer is incorporated or organized, or, in the case of an alien Insurer, its state of entry.

(7) "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

(8) "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

(9) "Noncompacting State" means any State which is not at the time a Compacting State.

(10) "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard, or a provision of this Compact.

(11) "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an Insurer is authorized to issue.

(12) "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice

requirements of the Commission, which shall have the force and effect of law in the Compacting States.

(13) "State" means any state, district, or territory of the United States of America.

(14) "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

(15) "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable, or against public policy as determined by the Commission.

ARTICLE III. ESTABLISHMENT OF THE COMMISSION AND VENUE

(1) The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

(2) The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

(3) The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

(4) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV. POWERS OF THE COMMISSION

The Commission shall have the following powers:

(1) To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

(2) To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in

this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

(3) To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

(4) To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

(5) To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

(6) To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

(7) To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) To establish and maintain offices;

(10) To purchase and maintain insurance and bonds;

(11) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compacting State;

(12) To hire employees, professionals, or specialists, and elect or appoint

officers, and to fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(16) To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules, or Operating Procedures;

(17) To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures, and Bylaws;

(18) To provide for dispute resolution among Compacting States;

(19) To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

(21) To establish a budget and make expenditures;

(22) To borrow money;

(23) To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

(24) To provide and receive information from, and to cooperate with law enforcement agencies;

(25) To adopt and use a corporate seal; and

(26) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V. ORGANIZATION OF THE COMMISSION

(1) Membership, Voting, and Bylaws.

(a) Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

(b) Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (<sfr>2/3<efr>) of the Members vote in favor thereof.

(c) The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

(i) Establishing the fiscal year of the Commission;

(ii) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

(iii) Providing reasonable standards and procedures: (aa) for the establishment and meetings of other committees, and (bb) governing any general or specific delegation of any authority or function of the Commission;

(iv) Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public: (aa) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (bb) votes taken during such meeting;

(v) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(vi) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(vii) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) Providing a mechanism for winding up the operations of the Commission and

the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

(d) The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

(2) Management Committee, Officers, and Personnel.

(a) A Management Committee comprising no more than fourteen (14) members shall be established as follows:

(i) One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year;

(ii) Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

(iii) Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

(b) The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

(i) Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

(ii) Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (<sfr>2/3<efr>) of the members of the Management Committee;

(iii) Overseeing the offices of the Commission; and

(iv) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the Commission.

(c) The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

(d) The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and

conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

(3) Legislative and Advisory Committees.

(a) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget, or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

(b) The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(c) The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

(4) Corporate Records of the Commission.

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

(5) Qualified Immunity, Defense, and Indemnification.

(a) The Members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

(b) The Commission shall defend any Member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

(c) The Commission shall indemnify and hold harmless any Member, officer, executive director, employee, or representative of the Commission for the amount

of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI. MEETINGS AND ACTS OF THE COMMISSION

(1) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(2) Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

(3) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

ARTICLE VII. RULES AND OPERATING PROCEDURES; RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

(1) ***Rulemaking Authority.*** The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

(2) ***Rulemaking Procedure.*** Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981, as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(3) ***Effective Date and Opt Out of a Uniform Standard.*** A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure, or amendment.

(4) ***Opt Out Procedure.*** A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department

under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Compact; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

(5) ***Effect of Opt Out.*** If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

(6) ***Stay of Uniform Standard.*** If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and, while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking

process has been terminated.

(7) Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII. COMMISSION RECORDS AND ENFORCEMENT

(1) The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(2) Except as to privileged records, data, and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data, or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

(3) The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

(4) The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

(a) With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards, or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the

Insurer and an opportunity for hearing before the Commission.

(b) Before a Commissioner may bring an action for violation of any provision, standard, or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX. DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

ARTICLE X. PRODUCT FILING AND APPROVAL

(1) Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

(2) The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

(3) Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

ARTICLE XI. REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

(1) Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section (4).

(2) The Commission shall have authority to monitor, review, and reconsider

Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section (1) above.

ARTICLE XII. FINANCE

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

(2) The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

(3) The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

(4) The Commission shall be exempt from all taxation in and by the Compacting States.

(5) The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

(6) The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(7) No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII. COMPACTING STATES, EFFECTIVE DATE, AND AMENDMENT

(1) Any State is eligible to become a Compacting State.

(2) The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

(3) Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

ARTICLE XIV. WITHDRAWAL, DEFAULT, AND TERMINATION

(1) Withdrawal.

(a) Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph (e) of this section.

(c) The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

(d) The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

(e) The Withdrawing State is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

(2) Default.

(a) If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges, and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges, and benefits conferred by this Compact shall be terminated from the effective date of termination.

(b) Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section (1) of this article.

(c) Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

(3) Dissolution of Compact.

(a) The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

(b) Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

ARTICLE XV. SEVERABILITY AND CONSTRUCTION

(1) The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(2) The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI. BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) Other Laws.

(a) Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph (b) of this section.

(b) For any Product approved or certified to the Commission, the Rules, Uniform Standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard, or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual States shall be subject to the laws of those States.

(2) Binding Effect of this Compact.

(a) All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

(b) All agreements between the Commission and the Compacting States are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers, or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Renumbered from R.S. 22:1450.51 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 353, § 1.

§ 2382. Louisiana compact commission official

Pursuant to the terms and conditions of this Part, the state of Louisiana seeks to join with other states and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission. The commissioner of insurance is hereby designated to serve as the representative of this state to the commission.

Renumbered from R.S. 22:1450.52 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2008, No. 353, § 1.

CHAPTER 18. INTERNAL CLAIMS AND APPEALS PROCESS AND EXTERNAL REVIEW ACT

Enactment; Repeal; Delayed Effective Date—Acts 2013, No. 326

Acts 2013, No. 326, § 1 adds Chapter 18, "Internal Claims and Appeals Process and External Review Act", of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2391 to 22:2453. Section 2 of Act 326 repeals Subpart F, "Medical Necessity Review Organizations" of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes, comprised of R.S. 22:1121 to 22:1144. Act 326 also amends provisions of R.S. 22:821. Section 3 provides a January 1, 2015 effective date for Act 326.

PART I. TITLE, DEFINITIONS, AND LICENSURE

§ 2391. Purpose; short title

A. This Chapter shall be known and may be cited as the "Internal Claims and Appeals Process and External Review Act".

B. The purpose of this Chapter is the following:

(1) To establish standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.

(2) To provide standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for the appropriate resolution of internal and external appeals, as defined in this Chapter.

(3) To provide uniform standards for the establishment and maintenance of an internal claims and appeals process and external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Chapter.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2392. Definitions

As used in this Chapter:

(1) "Adverse determination" means any of the following:

(a) A determination by a health insurance issuer or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

(b) The denial, reduction, termination, or failure to provide or make payment,

in whole or in part, for a benefit based on a determination by a health insurance issuer or its designee utilization review organization of a covered person's eligibility to participate in the health insurance issuer's health benefit plan.

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.

(d) A rescission of coverage determination.

(e) For purposes of this Chapter, Part III of this Chapter relative to external reviews shall apply only to adverse determinations and final adverse determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness, experimental or investigational treatment, or a rescission. Part II of this Chapter shall apply to any other adverse determination or final adverse determination.

(2) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(3) "Authorized representative" means any of the following:

(a) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Chapter. It may also 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 other coinsurance amount. In the event that the service is determined not to be medically necessary, and the covered person or his authorized representatives, except for the covered person's treating health care professional, thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all non-medically necessary services provided.

(b) A person authorized by law to provide substituted consent for a covered person.

(c) An immediate family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

(d) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

(4) "Best evidence" means evidence based on any of the following:

(a) Randomized clinical trials.

(b) If randomized clinical trials are not available, cohort studies, or case-control studies.

(c) If Subparagraphs (a) and (b) of this Paragraph are not available, case-series.

(d) If Subparagraphs (a), (b), and (c) of this Paragraph are not available, expert opinion.

(5) "Business day" means a day of normal business operation other than federally recognized holidays. Any day not specified as a business day shall be a twenty-four-hour period, including weekends and holidays.

(6) "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(7) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(8) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) "Certification" or "certify" means a determination by a health insurance issuer or its designee utilization review organization that a request for a benefit under the health insurance issuer's health benefit plan has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

(10) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

(11) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health insurance issuer to determine the medical necessity and appropriateness of health care services including those used in the determination of an item or health care service as experimental.

(12) "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or interventions.

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

(14) "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

(15) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(16) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(17) "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.

(18) "Disclose" means to release, transfer, or otherwise divulge protected health

information to any person other than the individual who is the subject of the protected health information.

(19) "Emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(20) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(21) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(22) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

(23) "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 centers, residential treatment centers, diagnostic, laboratory and imaging centers, rehabilitation and other therapeutic health settings, and inpatient hospice facilities.

(24) "Final adverse determination" means an adverse determination, including medical judgment, involving a covered benefit that has been upheld by a health insurance issuer, or its designee utilization review organization, at the completion of the health insurance issuer's internal claims and appeals process procedures provided pursuant to R.S. 22:2401.

(25) "Grievance" means, in a health insurance issuer's internal claims and appeals process, a written complaint or oral complaint, if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding any of the following:

(a) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(b) Claims payment, handling, or reimbursement for health care services.

(c) Matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

(26) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:1061 and short-term policies that have a term of less than twelve months.

(27) "Health care professional" means a physician or other health care practitioner licensed, accredited, registered, or certified to perform specified health care services consistent with state law.

(28) "Health care provider" or "provider" means a health care professional or a facility.

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

(30) "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 an individual or a member of the individual's family.

(b) The provision of health care services to an individual.

(c) Payment for the provision of health care services to an individual.

(31) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including through a health benefit plan as defined in this Section, and shall include a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, or any other entity providing a plan of health insurance or health benefits.

(32) "Immediately" means as expeditiously as the medical situation of the covered person requires but in no event longer than one day for expedited reviews or one business day for standard reviews.

(33) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

(34) "Medical or scientific evidence" means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medica (EMBASE).

(c) Medical journals recognized by the secretary of the United States Department of Health and Human Services under Section 1861(t)(2) of the federal Social

Security Act.

(d) The following standard reference compendia:

(i) The American Hospital Formulary Service-Drug Information.

(ii) Drug Facts and Comparisons.

(iii) The American Dental Association Guide to Dental Therapeutics.

(iv) The United States Pharmacopeia-Drug Information.

(e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including:

(i) The federal Agency for Healthcare Research and Quality.

(ii) The National Institutes of Health.

(iii) The National Cancer Institute.

(iv) The National Academy of Sciences.

(v) The federal Centers for Medicare and Medicaid Services.

(vi) The federal Food and Drug Administration.

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(f) Any other medical or scientific evidence that is comparable to the sources listed in Subparagraphs (a) through (e) of this Paragraph.

(35) "NAIC" means the National Association of Insurance Commissioners.

(36) "Person" or "entity" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(37) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health insurance issuer's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

(38) "Protected health information" means either of the following:

(a) Health information that identifies an individual who is the subject of the information.

(b) Health information with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(39) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(40) "Rescission" means cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. The term shall not include a cancellation or discontinuance of coverage under a health benefit plan if either:

(a) The cancellation or discontinuance of coverage has only a prospective effect.

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(41) "Retrospective review" means a utilization review conducted after services have been provided to a patient, but does 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.

(42) "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 care service to assess the clinical or medical necessity and appropriateness of the initial proposed health care service.

(43) "Urgent care request" means:

(a) A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination either:

(i) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

(ii) Would, in the opinion of a physician with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b)(i) Except as provided in Item (ii) of this Subparagraph, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Subparagraph (a) of this Paragraph shall be treated as an urgent care request.

(44) "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical or medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(45) "Utilization review organization" means a licensed entity that conducts utilization review in the internal claims and appeals process provided pursuant to R.S. 22:2401.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2393. Applicability and scope

This Chapter shall apply to any health insurance issuer that offers a health benefit plan as defined in this Chapter.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2394. Licensure as a utilization review organization

A. No health insurance issuer, or entity acting on behalf of, or agent of a health insurance issuer shall act as a utilization review organization unless authorized as such by the commissioner as provided in this Chapter.

B. Any other entity may apply for and be issued a license pursuant to this Chapter to act as a utilization review organization on behalf of a health insurance issuer.

C. An entity licensed as a utilization review organization shall notify the commissioner of any material change in fact or circumstance affecting its qualification for a license in this state within sixty days of the effective date of the change. The notice shall include any documentation that the commissioner may require. Changes in fact or circumstances shall include the following items:

(1) Changes in control as defined in R.S. 22:691.2.

(2) Amendments to the articles of incorporation.

(3) Changes in officers and directors.

(4) Merger or consolidation of the utilization or independent review organization with any other person or entity.

(5) Use of a trade name in this state.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2395. Procedure for application to act as a utilization review organization

A. Any applicant for licensure as a utilization review organization, other than a health insurance issuer, shall submit an application to the commissioner and pay the application fee specified in R.S. 22:821(B)(36). 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 not be limited to the following:

(1) The name of the entity operating as a utilization review organization and any trade or business names used by that entity in connection with making

utilization review determinations.

(2) The names and addresses of every officer and director of the entity operating as a utilization review organization, the name and address of the corporate officer designated by the utilization review organization as the corporate representative to oversee the utilization review, and such biographical information as may be requested by the commissioner.

(3) The name and address of every person owning, directly or indirectly, ten percent or more of the entity operating as a utilization review organization as well as such biographical information as may be requested by the commissioner.

(4) The principal place of business of the utilization review organization.

(5) A general description of the operation of the utilization review organization which includes a statement that the utilization review organization does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

(6) A copy of the utilization review organization's procedure manual which meets the requirements of this Chapter for making utilization review.

(7) A sample copy of any contract, absent fees charged, for making utilization review determinations that is entered into with a health insurance issuer, nonfederal government health benefit plan, or other group health plan.

(8) The names, addresses, and qualifications of individuals being designated to make utilization review 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 a utilization review organization under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include but not be limited to the following:

(1) A general description of the operation of the utilization review organization which includes a statement that the utilization review organization does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

(2) A copy of the utilization review organization's program description or procedures manual which meets the requirements of this Chapter for making clinical or medical necessity determinations and resolving disputes in the internal claims and appeals process.

(3) A sample copy of any contract, absent fees charged, for making utilization review determinations that is entered into with another health insurance issuer.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

PART II. INTERNAL CLAIMS AND APPEALS PROCESS

§ 2401. Requirements of federal laws and regulations; minimum requirements

Health insurance issuers shall implement effective processes for appeals of coverage determinations and claims pursuant to Section 2719 of the Public Health Service Act (42 U.S.C. 300gg-19) and any federal regulations promulgated pursuant thereto by the United States Department of Labor and the United States Department of Health and Human Services. Under such processes, a health insurance issuer shall, at a minimum:

(1) Have in effect an internal claims appeal process.

(2) Provide notice to covered persons, in a culturally and linguistically appropriate manner, of available internal and external appeals processes and the availability of the office of consumer advocacy of the Department of Insurance to assist such persons with the appeals process.

(3) Allow covered persons, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the appeals process where required by applicable law or the plan document or policy.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

PART III. HEALTH INSURANCE ISSUER EXTERNAL REVIEW ACT

§§ 2411 to 2430. Redesignated as R.S. 22:550.1 to 22:550.20

§ 2431. Short title

This Part shall be known and may be cited as the "Health Insurance Issuer External Review Act".

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2432. Purpose and intent

The purpose of this Part is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Chapter.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2433. Notice of right to external review

A. (1) For matters involving an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness, or a rescission, a health insurance issuer shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to R.S. 22:2436 through 2438 and include the appropriate statements and information set forth in Subsection B of this Section at the same time that the health insurance issuer sends written notice of:

(a) An adverse determination upon completion of the health insurance issuer's

internal claims and appeals process provided pursuant to R.S. 22:2401.

(b) A final adverse determination.

(2) As part of the written notice required pursuant to Paragraph (1) of this Subsection, a health insurance issuer shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us. In order to request an external appeal, you should send your request in writing to our office at the designated address included in this notice."

(3) The commissioner may prescribe by regulation the form and content of the notice required pursuant to this Section.

B. (1) The health insurance issuer shall include in the notice required pursuant to Subsection A of this Section:

(a) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time frame for completion of an expedited review of a grievance involving an adverse determination as provided pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review to be conducted pursuant to R.S. 22:2437. Further, the notice shall inform the covered person that an expedited external review pursuant to R.S. 22:2438 is available if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person. The notice shall also inform the covered person or his authorized representative that he may simultaneously file a request for an expedited review of a grievance involving an adverse determination as provided pursuant to R.S. 22:2401, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.

(ii) The covered person or his authorized representative may file a grievance under the health insurance issuer's internal claims and appeals process as provided pursuant to R.S. 22:2401, but if the health insurance issuer has not issued a written decision to the covered person or his authorized representative within thirty days following the date the covered person or his authorized representative files the grievance with the health insurance issuer and the covered person or his authorized representative has not requested or agreed to a delay, the covered person or his authorized representative may file a request for external review pursuant to R.S. 22:2434 and shall be considered to have exhausted the health insurance issuer's internal claims and appeals process for

purposes of R.S. 22:2435.

(b) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time frame for completion of a standard external review pursuant to R.S. 22:2436 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review pursuant to R.S. 22:2437.

(ii) If the final adverse determination concerns either of the following:

(aa) An admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or his authorized representative may request an expedited external review pursuant to R.S. 22:2437.

(bb) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or his authorized representative may file a request for a standard external review to be conducted pursuant to R.S. 22:2438 or if the covered person's treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person, the covered person or his authorized representative may request an expedited external review to be conducted under R.S. 22:2438.

(2) In addition to the information to be provided pursuant to Paragraph (1) of this Subsection, the health insurance issuer shall include a copy of the description of both the standard and expedited external review procedures the health insurance issuer is required to provide pursuant to R.S. 22:2445, highlighting the provisions in the external review procedures that give the covered person or his authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(3) As part of any forms provided under Paragraph (2) of this Subsection, the health insurance issuer shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this Part, authorizes the health insurance issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as further provided in this Paragraph. A health insurance issuer shall not use or disclose protected health information for any purpose other than in the performance of the health insurance issuer's functions, except as otherwise permitted by state or federal law, including providing such information to an independent review organization as required by this Part.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2434. Request for external review

A. (1) Except for a request for an expedited external review, all requests for external review shall be made in writing to the health insurance issuer.

(2) The commissioner may prescribe by regulation the form and content of external review requests required to be submitted pursuant to this Section.

B. A covered person or his authorized representative may make a request for an external review of an adverse determination or final adverse determination when such determination involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness, or a rescission.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2435. Exhaustion of internal claims and appeals process

A. (1) Except as provided in Subsection B of this Section, a request for an external review pursuant to R.S. 22:2436 through 2438 shall not be made until the covered person has exhausted the health insurance issuer's internal claims and appeals process provided pursuant to R.S. 22:2401.

(2) In addition, a covered person shall be considered to have exhausted the health insurance issuer's internal claims and appeals process for purposes of this Section, if both of the following conditions are met:

(a) The covered person or his authorized representative, if applicable, has filed a grievance involving an adverse determination as provided pursuant to R.S. 22:2401.

(b) Except to the extent the covered person or his authorized representative has requested or agreed to a delay, the covered person or his authorized representative has not received a written decision on the grievance from the health insurance issuer within thirty days following the date that the covered person or his authorized representative filed the grievance with the health insurance issuer.

(3) Notwithstanding Paragraph (2) of this Subsection, a covered person or his authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to R.S. 22:2401 until the covered person has exhausted the health insurance issuer's internal claims and appeals process.

B. (1)(a) At the same time that a covered person or his authorized representative files a request for an expedited review of a grievance involving an adverse determination as provided pursuant to R.S. 22:2401, the covered person or his authorized representative may file a request for an expedited external review of the adverse determination for either of the following:

(i) Pursuant to R.S. 22:2437, if the covered person has a medical condition in which the time frame for completion of an expedited review of the grievance involving an adverse determination made pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(ii) Pursuant to R.S. 22:2438, if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person.

(b) Upon receipt of a request for an expedited external review under Subparagraph (a) of this Paragraph, the independent review organization conducting the external review in accordance with the provisions of R.S. 22:2437 or 2438 shall determine whether the covered person shall be required to complete the expedited grievance review process as provided pursuant to R. S. 22:2401 before it conducts the expedited external review.

(c) Upon a determination made pursuant to Subparagraph (b) of this Paragraph that the covered person must first complete the expedited grievance review process as provided pursuant to R.S. 22:2401, the independent review organization shall immediately notify the covered person and, if applicable, his authorized representative of this determination and that the independent review organization will not proceed with the expedited external review provided for by R.S. 22:2437 or 2438 until completion of the expedited grievance review process if the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(2) A request for an external review of an adverse determination may be made before the covered person has exhausted the health insurance issuer's internal grievance procedures as provided pursuant to R.S. 22:2401 whenever the health insurance issuer agrees to waive the exhaustion requirement.

(3) A request for an external review of an adverse determination may be made before the covered person has exhausted the health insurance issuer's internal grievance procedures as provided pursuant to R.S. 22:2401 whenever the health insurance issuer fails to adhere to requirements pursuant to R.S. 22:2401. Notwithstanding the provisions of this Paragraph, the internal claims and appeals process will not be deemed exhausted based on de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the health insurance issuer demonstrates that the violation was for good cause or due to matters beyond the control of the health insurance issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health insurance issuer and the claimant. This exception shall not be available if the violation is part of a pattern or practice of violations by the health insurance issuer.

C. If the requirement to exhaust the health insurance issuer's internal grievance procedures is waived under Paragraph (B)(2) of this Section, the covered person or his authorized representative may file a request in writing for a standard external review as provided for by R.S. 22:2436 or 2438.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2436. Standard external review

A. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to R.S. 22:2433, a covered person or his authorized representative may file a request for an external review with the health insurance issuer, regardless of the claim amount.

B. Within five business days following the date of receipt of the external review request from the covered person or his authorized representative pursuant to Subsection A of this Section, the health insurance issuer shall complete a preliminary review of the request to determine whether all of the following have been met:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The health care service is the subject of an adverse determination or a final adverse determination.

(3) The covered person has exhausted the health insurance issuer's internal claims and appeals process as provided pursuant to R.S. 22:2401 unless the covered person is not required to exhaust the health insurance issuer's internal claims and appeals process pursuant to R.S. 22:2435.

(4) The covered person has provided all the information and forms required to process an external review, including the authorization form provided for in R.S. 22:2433(B).

C. (1) Within the five business days allowed for the completion of the preliminary review, the health insurance issuer shall notify the commissioner as provided pursuant to Subsection D of this Section and notify the covered person and, if applicable, his authorized representative of all the following, in writing, whether:

(a) The request is complete.

(b) The request is eligible for external review.

(2) If the request:

(a) Is not complete, the health insurance issuer shall inform the covered person and, if applicable, his authorized representative in writing and include in the notice what information or materials are needed to make the request complete.

(b) Is not eligible for external review, the health insurance issuer shall inform the covered person and, if applicable, his authorized representative in writing and include in the notice the reasons for its ineligibility.

(3)(a) The commissioner may specify the form and method for the health insurance issuer's notice of initial determination pursuant to Paragraph (2) of this Subsection and any supporting information to be included in the notice.

(b) The notice of initial determination pursuant to Paragraph (2) of this Subsection shall include a statement informing the covered person and, if

applicable, his authorized representative that a health insurance issuer's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4)(a) If the covered person or his authorized representative makes a written request to the commissioner of insurance after the receipt of the denial of an external review, the commissioner may determine that a request is eligible for external review pursuant to Subsection B of this Section, notwithstanding a health insurance issuer's initial determination that the request is ineligible, and require that it be referred for external review.

(b) In making a determination under Subparagraph (a) of this Paragraph, the commissioner's decision shall be made in accordance with all applicable provisions of this Part.

(c) The commissioner shall notify the health insurance issuer and the covered person or his authorized representative of his determination about the eligibility of the request within five business days of the receipt of the request from the covered person. Within one business day of receipt of the commissioner's determination that a request is eligible for an external review, a health insurance issuer shall comply with Subsection D of this Section.

D. (1) A health insurance issuer shall notify the commissioner that a request is eligible for external review pursuant to Subsection C of this Section by submitting a request for assignment of an independent review organization through the Department of Insurance's website. Upon notification, the commissioner shall do the following:

(a) Randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2440 to conduct the external review and notify the health insurance issuer of the name of the assigned independent review organization.

(b) Within one business day, send written notice to the covered person and, if applicable, his authorized representative, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned independent review organization.

(2) In reaching a decision, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health insurance issuer's internal claims and appeals process as provided pursuant to R.S. 22:2401.

(3) The commissioner shall include in the notice provided to the covered person and, if applicable, his authorized representative a statement that the covered person or his authorized representative may submit in writing to the assigned independent review organization, within five business days following the date of receipt of the notice provided pursuant to Subparagraph (1)(b) of this Subsection, additional information that the independent review organization shall consider when conducting the external review. The independent review organization shall be authorized but not required to accept and consider additional information submitted after five business days.

E. (1) Within five business days after the date of receipt of the notice provided pursuant to Subparagraph (D)(1)(b) of this Section, the health insurance issuer

or its utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in Paragraph (3) of this Subsection, failure by the health insurance issuer or its utilization review organization to provide the documents and information within the time frame specified in Paragraph (1) of this Subsection shall not delay the conduct of the external review.

(3)(a) If the health insurance issuer or its utilization review organization fails to provide the documents and information within the time frame specified in Paragraph (1) of this Subsection, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Within one business day after making the decision under Subparagraph (a) of this Paragraph, the independent review organization shall notify the covered person in writing, if applicable, his authorized representative, the health insurance issuer, and the commissioner.

F. (1) The assigned independent review organization shall review all of the information and documents received pursuant to Subsection E of this Section and any other information timely submitted in writing to the independent review organization by the covered person or his authorized representative pursuant to Paragraph (D)(3) of this Section.

(2) Upon receipt of any information submitted by the covered person or his authorized representative pursuant to Paragraph (D)(3) of this Section, the assigned independent review organization shall, within one business day, forward the information to the health insurance issuer.

G. (1) Upon receipt of the information, if any, required to be forwarded pursuant to Paragraph (F)(2) of this Section, the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to Paragraph (1) of this Subsection shall not delay or terminate the external review.

(3) The external review may be terminated only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(4)(a) Within one business day after making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3) of this Subsection, the health insurance issuer shall notify the covered person, if applicable, his authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health insurance issuer sent pursuant

to Subparagraph (a) of this Paragraph.

H. In addition to the documents and information provided pursuant to Subsection E of this Section, the assigned independent review organization, to the extent that the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) The attending health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, covered person, his authorized representative, or the covered person's treating provider.

(4) The terms of coverage under the covered person's health benefit plan with the health insurance issuer to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer.

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(6) Any applicable clinical review criteria developed and used by the health insurance issuer or its designee utilization review organization.

(7) The opinion of the independent review organization's clinical peer or peers after considering Paragraphs (1) through (6) of this Subsection to the extent the information or documents are available and the clinical peer or peers consider appropriate.

I. (1) Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to each of the following:

(a) The covered person.

(b) If applicable, the covered person's authorized representative.

(c) The health insurance issuer.

(d) The commissioner.

(2) The independent review organization shall include the following in the notice sent pursuant to Paragraph (1) of this Subsection:

(a) A general description of the reason for the request for external review.

(b) The date that the independent review organization received the assignment from the commissioner to conduct the external review.

(c) The date that the external review was conducted.

(d) The date of its decision.

(e) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were a basis for its decision.

(f) The rationale for its decision.

(g) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(3) Upon receipt of a notice of a decision made pursuant to Paragraph (1) of this Subsection reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve the coverage or payment that was the subject of the adverse determination or final adverse determination.

J. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to R.S. 22:2441(D).

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2437. Expedited external review

A. Except as provided in Subsection F of this Section, a covered person or his authorized representative may make a request regardless of the claim amount for an expedited external review with the health insurance issuer at the time that the covered person receives:

(1) An adverse determination if both of the following apply:

(a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination made pursuant to R.S. 22:2401 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) The covered person or his authorized representative has filed a request for an expedited review of a grievance involving an adverse determination made pursuant to R.S. 22:2401.

(2) A final adverse determination if either of the following applies:

(a) The covered person has a medical condition in which the time frame for completion of a standard external review pursuant to R.S. 22:2436 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) The final adverse determination concerns an admission, availability of care,

continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. (1) Immediately upon receipt of the request pursuant to Subsection A of this Section, the health insurance issuer shall determine whether the request meets the reviewability requirements specified in R.S. 22:2436(B). The health insurance issuer shall immediately notify the covered person and, if applicable, his authorized representative of its eligibility determination.

(2)(a) The commissioner may specify the form and method for the health insurance issuer's notice of initial determination pursuant to Paragraph (1) of this Subsection and any supporting information to be included in the notice.

(b) The notice of initial determination pursuant to Paragraph (1) of this Subsection shall include a statement informing the covered person and, if applicable, his authorized representative that a health insurance issuer's initial determination that an expedited external review request is ineligible for review may be appealed to the commissioner.

(3)(a) If the covered person or his authorized representative makes a written request to the commissioner of insurance after receipt of the notice of denial of an expedited external review, the commissioner may determine that a request is eligible for an expedited external review in accordance with the criteria found in R.S. 22:2436(B), notwithstanding a health insurance issuer's initial determination that the request is ineligible, and require that it be referred for external review.

(b) In making a determination under Subparagraph (a) of this Paragraph, the commissioner's decision shall be made in accordance with all applicable provisions of this Part.

(c) The commissioner shall immediately notify the health insurance issuer and the covered person or his authorized representative of its determination about the eligibility of the request. Following receipt of the commissioner's determination that a request is eligible for an expedited external review, a health insurance issuer shall immediately comply with Paragraph (4) of this Subsection.

(4) Immediately upon the health insurance issuer's determination that a request is eligible for an expedited external review or upon the determination by the commissioner that a request is eligible for an expedited external review, the health insurance issuer shall submit a request for assignment of an independent review organization through the Department of Insurance's website. Upon receipt of the notice that the request meets the reviewability requirements, the commissioner shall immediately assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2440. The commissioner shall immediately notify the health insurance issuer and the covered person or his authorized representative of the name and contact information of the assigned independent review organization.

(5) In reaching a decision in accordance with Subsection E of this Section, the assigned independent review organization is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review

process or the health insurance issuer's internal claims and appeals process provided pursuant to R.S. 22:2401.

C. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to Paragraph (B)(4) of this Section, the health insurance issuer or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone or facsimile, or by any other available expeditious method.

D. In addition to the documents and information provided or transmitted pursuant to Subsection C of this Section, the assigned independent review organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) The attending health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, his authorized representative, or the covered person's treating provider.

(4) The terms of coverage under the covered person's health benefit plan with the health insurance issuer to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer.

(5) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(6) Any applicable clinical review criteria developed and used by the health insurance issuer or its designee utilization review organization in making adverse determinations.

(7) The opinion of the independent review organization's clinical peer or peers after considering the information specified by Paragraphs (1) through (6) of this Subsection to the extent the information and documents are available and the clinical peer or peers consider appropriate.

E. (1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date that the health insurance issuer receives the request for an expedited external review, the assigned independent review organization shall do both of the following:

(a) Make a decision to uphold or reverse the adverse determination or final adverse determination.

(b) Notify the covered person, his authorized representative, if applicable, the health insurance issuer, and the commissioner of the decision.

(2) If the notice provided pursuant to Paragraph (1) of this Subsection was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall do both of the following:

(a) Provide written confirmation of the decision to the covered person, his authorized representative, if applicable, the health insurance issuer, and the commissioner.

(b) Include the information specified in R.S. 22:2436(I)(2).

(3) Upon receipt of the notice of a decision pursuant to Paragraph (1) of this Subsection reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review shall not be provided for retrospective adverse determinations or retrospective final adverse determinations.

G. The assignment by the commissioner of an approved independent review organization to conduct an expedited external review in accordance with this Section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular expedited external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to R.S. 22:2441(D).

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2438. External review of experimental or investigational treatment adverse determinations

A. (1) Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to R.S. 22:2433 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or his authorized representative may file a request for a standard and an expedited external review with the health insurance issuer, regardless of the claim amount.

(2)(a) A covered person or his authorized representative may make an oral request to the health insurance issuer for an expedited external review of the adverse determination or final adverse determination pursuant to Paragraph (1) of this Subsection if the covered person's treating physician certifies, in writing, that any delay in appealing the adverse determination may pose an imminent and serious threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the covered person.

(b)(i) Upon notice of the request for an expedited external review, the health insurance issuer shall immediately determine whether the request meets the reviewability requirements of Subsection B of this Section. The health insurance issuer shall immediately notify the covered person and, if applicable, his authorized representative of its eligibility determination.

(ii) The commissioner may specify the form and method for the health insurance issuer's notice of initial determination pursuant to Item (i) of this Subparagraph and any supporting information to be included in the notice.

(iii) The notice of initial determination under Item (i) of this Subparagraph shall include a statement informing the covered person and, if applicable, his authorized representative that a health insurance issuer's initial determination that the expedited external review request is ineligible for review may be appealed to the commissioner.

(c)(i) If the covered person or his authorized representative makes a written request to the commissioner of insurance after receipt of the denial of an expedited external review, the commissioner may determine that a request is eligible for an expedited external review pursuant to Subsection B of this Section, notwithstanding a health insurance issuer's initial determination the request is ineligible, and require that it be referred for an expedited external review.

(ii) In making a determination pursuant to Item (i) of this Subparagraph, the commissioner's decision shall be made in accordance with all applicable provisions of this Part.

(iii) The commissioner shall immediately notify the health insurance issuer and the covered person or his authorized representative of its determination concerning the eligibility of the request. Following receipt of the commissioner's determination that a request is eligible for an expedited external review, a health insurance issuer shall immediately comply with Subparagraph (d) of this Paragraph.

(d) Immediately upon the health insurance issuer's determination that a request is eligible for an expedited external review or upon the determination by the commissioner that a request is eligible for an expedited external review, the health insurance issuer shall submit a request for assignment of an independent review organization through the Department of Insurance's website. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of Subsection B of this Section, the commissioner shall immediately randomly assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by him pursuant to R.S. 22:2440 and notify the health insurance issuer and the covered person or his authorized representative of the name and contact information of the assigned independent review organization.

(e) At the time that the health insurance issuer receives the notice of the assigned independent review organization pursuant to Subparagraph (d) of this Paragraph, the health insurance issuer or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone or facsimile, or any other available expeditious method.

B. Within five business days following the date of receipt of the standard external review request, the health insurance issuer shall conduct and complete a preliminary review of the request to determine whether each of the following conditions have been met:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided.

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health insurance issuer.

(3) The covered person's treating physician has certified that one of the following situations exists:

(a) Standard health care services or treatments have not been effective in improving the condition of the covered person.

(b) Standard health care services or treatments are not medically appropriate for the covered person.

(c) There is no available standard health care service or treatment covered by the health insurance issuer that is more beneficial than the recommended or requested health care service or treatment.

(4) The covered person's treating physician either:

(a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments.

(b) Is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified, in writing, that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments.

(5) The covered person has exhausted the health insurance issuer's internal claims and appeals process provided pursuant to R.S. 22:2401, unless the covered person is not required to exhaust the health insurance issuer's internal claims and appeals process pursuant to R.S. 22:2435.

(6) The covered person has provided all the information and forms required by the commissioner that are necessary to process a standard external review, including the authorization form provided pursuant to R.S. 22:2433(B).

C. (1) Within five business days after the completion of the preliminary review, the health insurance issuer shall notify the covered person and, if applicable, his authorized representative in writing whether each of the following conditions have been met:

(a) The request is complete.

(b) The request is eligible for a standard external review.

(2) If the request:

(a) Is not complete, the health insurance issuer shall inform the covered person and, if applicable, his authorized representative in writing and specify in the notice what information or materials are needed to make the request complete.

(b) Is not eligible for a standard external review, the health insurance issuer shall inform the covered person and his authorized representative, if applicable, in writing and include in the notice the reasons for its ineligibility.

(3)(a) The commissioner may specify the form and method for the health insurance issuer's notice of initial determination pursuant to Paragraph (2) of this Subsection and any supporting information to be included in the notice.

(b) The notice of initial determination provided pursuant to Paragraph (2) of this Subsection shall include a statement informing the covered person and, if applicable, his authorized representative that a health insurance issuer's initial determination that the standard external review request is ineligible for review may be appealed to the commissioner.

(4)(a) If the covered person or his authorized representative makes a written request to the commissioner of insurance after receipt of the denial of a standard external review, the commissioner may determine that a request is eligible for a standard external review under Subsection B of this Section, notwithstanding a health insurance issuer's initial determination that the request is ineligible, and require that it be referred for a standard external review.

(b) In making a determination pursuant to Subparagraph (a) of this Paragraph, the commissioner's decision shall be made in accordance with all applicable provisions of this Part.

(c) The commissioner shall notify the health insurance issuer and the covered person or his authorized representative of his determination concerning the eligibility of the request within five business days. Following receipt of the commissioner's determination that a request is eligible for a standard external review, the health insurance issuer shall comply with Subsection D of this Section.

D. (1) A health insurance issuer shall notify the commissioner that a request is eligible for a standard external review pursuant to Subsection C of this Section by submitting a request for assignment of an independent review organization through the Department of Insurance's website. Upon notification, the commissioner shall do both of the following:

(a) Randomly assign an independent review organization to conduct the standard external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to R.S. 22:2440 and notify the health insurance issuer of the name of the assigned independent review organization.

(b) Within one business day, notify in writing the covered person and, if

applicable, his authorized representative of the request's eligibility and acceptance for a standard external review and the identity of and contact information for the assigned independent review organization.

(2) The commissioner shall include a statement in the notice provided to the covered person and, if applicable, his authorized representative that the covered person or his authorized representative may submit in writing to the assigned independent review organization, within five business days following the date of receipt of the notice provided pursuant to Paragraph (1) of this Subsection, additional information that the independent review organization shall consider when conducting the standard external review. The independent review organization shall be authorized but not required to accept and consider additional information submitted after five business days. Within one business day after the receipt of the notice of assignment to conduct the standard external review pursuant to Paragraph (1) of this Subsection, the assigned independent review organization shall follow the clinical peer process provided for in Paragraph (3) of this Subsection.

(3) For both a standard and an expedited external review, the assigned independent review organization shall do both of the following:

(a) Select one or more clinical peers, as it determines is appropriate, pursuant to Paragraph (4) of this Subsection, to conduct the standard or expedited external review.

(b) Based on the opinion of the clinical peer, or opinions if more than one clinical peer has been selected to conduct the standard or expedited external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(4)(a) In selecting clinical peers pursuant to Subparagraph (3)(a) of this Subsection, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications of R.S. 22:2441 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) The covered person, his authorized representative, if applicable, or the health insurance issuer shall not choose or control the choice of the physicians or other health care professionals to be selected to conduct the standard external review or the expedited external review.

(5) In accordance with Subsection H of this Section, each clinical peer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(6) In reaching an opinion, clinical peers shall not be bound by any decisions or conclusions reached during the health insurance issuer's utilization review process or the health insurance issuer's internal claims and appeals process provided pursuant to R.S. 22:2401.

E. (1) Within five business days after the date of receipt of the notice provided pursuant to Paragraph (D)(1) of this Section, the health insurance issuer or its

designee utilization review organization shall provide the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

(2) Except as provided in Paragraph (3) of this Subsection, failure by the health insurance issuer or its designee utilization review organization to provide the documents and information within the time frame specified in Paragraph (1) of this Subsection shall not delay the conduct of the standard external review or the expedited external review.

(3)(a) If the health insurance issuer or its designee utilization review organization has failed to provide the documents and information within the time frame specified in Paragraph (1) of this Subsection, the assigned independent review organization may terminate the standard external review or the expedited external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under Subparagraph (a) of this Paragraph, the independent review organization shall notify the covered person, his authorized representative, if applicable, the health insurance issuer, and the commissioner.

F. (1) For a standard or an expedited external review, each clinical peer selected pursuant to Subsection D of this Section shall review all of the information and documents received pursuant to Subsection E of this Section and any other information submitted in writing by the covered person or his authorized representative pursuant to Paragraph (D)(2) of this Section.

(2) Within one business day after receipt of any information submitted by the covered person or his authorized representative pursuant to Paragraph (D)(2) of this Section, the assigned independent review organization shall forward the information to the health insurance issuer.

G. (1) Upon receipt of the information required to be forwarded pursuant to Paragraph (F)(2) of this Section, the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the standard or the expedited external review.

(2) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to Paragraph (1) of this Subsection shall not delay or terminate the standard or the expedited external review.

(3) The standard or the expedited external review may terminate only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(4)(a) For a standard or an expedited review, immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Paragraph (3) of this Subsection, the health insurance issuer shall notify the covered person, his authorized representative, if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(b) The assigned independent review organization shall terminate the standard or the expedited external review upon receipt of the notice from the health insurance issuer sent pursuant to Subparagraph (a) of this Paragraph.

H. (1) Except as provided in Paragraph (3) of this Subsection, within twenty days after being selected in accordance with Subsection D of this Section to conduct the standard external review, each clinical peer shall provide an opinion to the assigned independent review organization pursuant to Subsection I of this Section regarding whether the recommended or requested health care service or treatment should be covered.

(2) Except for an opinion provided pursuant to Paragraph (3) of this Subsection, each clinical peer's opinion for a standard review shall be in writing and include the following information:

(a) A description of the covered person's medical condition.

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care services or treatments and whether the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion.

(d) A description and analysis of any evidence-based standard.

(e) Information on whether the peer's rationale for the opinion is based on the provisions of Subparagraph (I)(5)(a) or (b) of this Section.

(3)(a) For an expedited external review, each clinical peer shall provide an opinion orally or in writing containing the information outlined in Paragraph (2) of this Subsection to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five days after being selected in accordance with Subsection D of this Section.

(b) If the opinion provided pursuant to Subparagraph (a) of this Paragraph was not in writing, within forty-eight hours following the date that the opinion was provided, the clinical peer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under Paragraph (2) of this Subsection.

I. In addition to the documents and information provided pursuant to Paragraph (A)(2) of this Section or Subsection E of this Section, each clinical peer selected to conduct a standard or an expedited review pursuant to Subsection D of this Section, to the extent the information or documents are available and the peer considers appropriate, shall consider the following in reaching an opinion pursuant to Subsection H of this Section:

(1) The covered person's pertinent medical records.

(2) The attending physician's or health care professional's recommendation.

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, covered person, his authorized representative, or his treating physician or health care professional.

(4) The terms of coverage under the covered person's health benefit plan with the health insurance issuer to ensure that, but for the health insurance issuer's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the peer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer.

(5) Either of the following:

(a) Whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition.

(b) Whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care service or treatment and whether the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

J. (1)(a) Except as provided in Subparagraph (b) of this Paragraph, within twenty days after the date it receives the opinion of each clinical peer made pursuant to Subsection I of this Section, the assigned independent review organization in a standard external review, in accordance with Paragraph (2) of this Subsection, shall make a decision and provide written notice of the decision to:

(i) The covered person.

(ii) If applicable, his authorized representative.

(iii) The health insurance issuer.

(iv) The commissioner.

(b)(i) For an expedited external review, within forty-eight hours after the date it receives the opinion of each clinical peer pursuant to Subsection I of this Section, the assigned independent review organization, in accordance with Paragraph (2) of this Subsection, shall make a decision and provide notice of the decision orally or in writing to the persons specified in Subparagraph (a) of this Paragraph.

(ii) If the notice provided under Item (i) of this Subparagraph was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons specified in Subparagraph (a) of this Paragraph and

include the information provided for in Paragraph (3) of this Subsection.

(2)(a) For a standard or an expedited review, if a majority of the clinical peers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health insurance issuer's adverse determination or final adverse determination.

(b) For a standard or an expedited external review, if a majority of the clinical peers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health insurance issuer's adverse determination or final adverse determination.

(c)(i) For a standard or an expedited external review, if the clinical peers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical peers made pursuant to Subparagraph (a) or (b) of this Paragraph.

(ii) The additional clinical peer selected under Item (i) of this Subparagraph shall use the same information to reach an opinion as the clinical peers who have already submitted their opinions pursuant to Subsection I of this Section.

(iii) The selection of the additional clinical peer under Item (i) of this Subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peers selected under Subsection D of this Section pursuant to Paragraph (1) of this Subsection.

(3) For a standard or an expedited appeal, the independent review organization shall include in the notice provided pursuant to Paragraph (1) of this Subsection:

(a) A general description of the reason for the request for external review.

(b) The written opinion of each clinical peer, including the recommendation of each clinical peer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the peer's recommendation.

(c) The date that the independent review organization was assigned by the commissioner to conduct the external review.

(d) The date that the external review was conducted.

(e) The date of its decision.

(f) The principal reason or reasons for its decision.

(g) The rationale for its decision.

(4) For a standard or an expedited external review, upon receipt of a notice of a decision pursuant to Paragraph (1) of this Subsection reversing the adverse determination or final adverse determination, the health insurance issuer shall

immediately approve coverage and payment of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

K. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to R.S. 22:2441(D).

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2439. Binding nature of external review decision

A. A standard or an expedited external review decision shall be binding on the health insurance issuer except to the extent the health insurance issuer has other remedies available under applicable federal or state law.

B. A standard or an expedited external review decision shall be binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or his authorized representative may not file a subsequent request for a standard or expedited external review involving the same adverse determination or final adverse determination for which the covered person has already received a standard or expedited external review decision pursuant to this Part.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2440. Approval of independent review organizations

A. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part.

B. In order to be eligible for approval by the commissioner under this Section to conduct external reviews under this Part, an independent review organization shall:

(1) Except as otherwise provided in this Section, be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations provided for pursuant to R.S. 22:2441.

(2) Submit an application for approval in accordance with Subsection D of this Section along with the application fee specified in R.S. 22:821(37). Such application shall also include a specified e-mail address to which external review information may be submitted.

C. The commissioner shall develop an application form for initially approving and for re-approving independent review organizations to conduct external

reviews.

D. (1) Any independent review organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications provided for by R.S. 22:2441.

(2)(a) Subject to Subparagraph (b) of this Paragraph, an independent review organization shall be eligible for approval under this Section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations provided for by R.S. 22:2441.

(b) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(3) The commissioner shall charge an application fee as specified in R.S. 22:821(37) that independent review organizations shall submit to the commissioner with an application for approval or re-approval.

E. (1) An approval shall be effective for two years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications provided for by R.S. 22:2441. An application for renewal shall be submitted not less than sixty days prior to the expiration of such approval, shall be made on a form provided by the commissioner, and shall be accompanied by the fee required by R.S. 22:821(37).

(2) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under R.S. 22:2441, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Part that is maintained by the commissioner pursuant to Subsection F of this Section.

F. The commissioner shall maintain and periodically update a list of approved independent review organizations.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2441. Minimum qualifications for independent review organizations

A. To be approved under R.S. 22:2440 to conduct external reviews, an independent review organization shall not be a health insurance issuer and shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process provided for in this Part. At a minimum, these shall include the following:

(1) A quality assurance mechanism in place that:

(a) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

(b) Ensures the selection of qualified and impartial clinical peers to conduct external reviews on behalf of the independent review organization and suitable matching of peers to specific cases and ensures that the independent review organization employs or contracts with an adequate number of clinical peers to meet this objective.

(c) Ensures the confidentiality of medical and treatment records and clinical review criteria.

(d) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

(2) A toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instructions to incoming telephone callers during other than normal business hours.

(3) An agreement to maintain and provide to the commissioner the information required pursuant to R.S. 22:2443.

B. Any clinical peer 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) Is an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(2) Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person.

(3) Has a nonrestrictive medical license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) Does not have a 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's physical, mental, or professional competence or moral character.

C. In addition to the requirements specified in Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with, a 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. (1) In addition to the requirements specified in Subsections A, B, and C of this Section, in order to be approved pursuant to R.S. 22:2440 to conduct an external review of a specified case, neither the independent review organization

selected to conduct the external review nor any clinical peer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(a) The health insurance issuer that is the subject of the external review.

(b) The covered person whose treatment is the subject of the external review or his authorized representative.

(c) Any officer, director, or management employee of the health insurance issuer that is the subject of the external review.

(d) The health care provider, his medical group, or his independent practice association recommending the health care service or treatment that is the subject of the external review.

(e) The facility at which the recommended health care service or treatment would be provided.

(f) 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.

(2) In determining whether an independent review organization or a clinical peer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of Paragraph (1) of this Subsection, the commissioner shall take into consideration situations in which the independent review organization or clinical peer to be assigned by the independent review organization to conduct an external review of a specified case may have such a relationship or connection with a person specified in Paragraph (1) of this Subsection, but that the characteristics of such relationship or connection are not a material conflict of interest that would result in the disapproval of the independent review organization or the clinical peer from conducting the external review.

E. (1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this Section shall be presumed in compliance with this Section and be eligible for approval pursuant to R.S. 22:2440.

(2) The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications provided for in this Section.

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications provided for in this Section.

F. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required by this Section.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2442. Hold harmless for external review procedures

No independent review organization or clinical peer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Part, unless the opinion was rendered or act or omission was performed in bad faith or involved negligence or gross negligence.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2443. External review reporting requirements

A. (1) An independent review organization assigned pursuant to R.S. 22:2436 through 2438 to conduct an external review shall maintain written records in the aggregate, by state, and by health insurance issuer on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required by Paragraph (2) of this Subsection.

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to Paragraph (1) of this Subsection for which it was assigned to conduct an external review shall submit to the commissioner an annual report. The annual report shall include each of the following:

(a) The total number of requests for external review.

(b) The number of requests for external review resolved and their resolution.

(c) A synopsis of actions being taken to correct problems identified.

(3) The report shall include in the aggregate, by state, and for each health insurance issuer:

(a) The total number of requests for external review.

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination.

(c) The average length of time for resolution.

(d) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner.

(e) The number of external reviews conducted pursuant to R.S. 22:2436(G) that were terminated as the result of a reconsideration by the health insurance issuer of its adverse determination or final adverse determination after the receipt of additional information from the covered person or his authorized representative.

(f) A general description for each request for external review including the following:

(i) A general description of the reason for the request for external review.

(ii) The date received.

(iii) The date of each review.

(iv) The resolution.

(v) The date of the resolution.

(vi) The name of the covered person for whom the request for external review was filed.

(g) Any other information that the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this Subsection for at least three years.

B. (1) Each health insurance issuer shall maintain written records in the aggregate, by state, and for each type of health benefit plan offered by the health insurance issuer, for all requests for external review that the health insurance issuer receives notice of from the commissioner pursuant to this Part.

(2) Each health insurance issuer required to maintain written records on all requests for external review pursuant to Paragraph (1) of this Subsection shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate, by state, and by type of health benefit plan:

(a) The total number of requests for external review.

(b) From the total number of requests for external review reported under Subparagraph (a) of this Paragraph, the number of requests determined eligible for an external review.

(c) Any other information the commissioner may request or require.

(4) The health insurance issuer shall retain the written records required pursuant to this Subsection for at least three years.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2444. Funding of external review

The health insurance issuer against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review, and no fee or other charge may be levied upon a covered person for any costs of an external review.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2445. Disclosure requirements

A. (1) Each health insurance issuer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage that it provides to covered persons.

(2) The description required by Paragraph (1) of this Subsection shall be in a format prescribed by the commissioner.

B. The description required by Subsection A of this Section shall include a statement that informs covered persons of their right to file a request for an external review of an adverse determination or final adverse determination with the health insurance issuer. The statement may explain that an external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the telephone number and address of the commissioner.

C. In addition to the requirements of Subsection B of this Section, the statement shall inform covered persons that, when filing a request for an external review, they will be required to authorize the release of any of their medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

PART IV. COMPLIANCE, PENALTIES, AND OTHER REGULATORY MATTERS

§ 2451. Confidentiality requirements

A health insurance issuer shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2452. Regulations; preemption

A. The commissioner may 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, R.S. 49:950 et seq.

B. If at any time a provision of this Chapter is in conflict with federal law or regulations promulgated pursuant to federal law, such a provision shall be preempted only to the extent necessary to avoid direct conflict with such federal law or regulations. The commissioner shall, pursuant to rule or regulation promulgated and adopted in accordance with the Administrative Procedure Act, subsequently administer and enforce this Chapter in a manner that conforms to such federal law or regulations.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.

§ 2453. Penalties; 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, utilization review organization, or independent review organization is not in full compliance with the provisions of this Chapter, he shall notify such person in accordance and compliance with the Administrative Procedure Act, R.S. 49:950 et seq., and the commissioner shall, in accordance and compliance with such Act, issue and cause to be served an order requiring the health insurance issuer, utilization review organization, or independent review organization 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 five hundred 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, utilization review organization, or independent review organization knew or reasonably should have known that 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 a utilization review organization, or withdrawal of the approval of the certification of an independent review organization if the health insurance issuer, utilization review organization, or independent review organization knew or reasonably should have known that it was in violation of this Chapter.

B. Any health insurance issuer, licensed utilization review organization, or certified independent review organization that violates a cease and desist order issued by the commissioner pursuant to this Chapter while such order is in effect shall 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 utilization review

organization or withdrawal of the approval of the certification of the independent review organization to operate in this state.

C. The commissioner may withdraw his approval of the certification of an independent review organization, or the commissioner may suspend or revoke the license of an utilization review organization or the authorization of a health insurance issuer to act as an utilization review organization. In lieu of such withdrawal of approval of its certification as an independent review organization, the suspension or revocation of a license of an utilization review organization, or revocation of a health insurance issuer's authority to act as an utilization review organization, 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 utilization review organization or the health insurance issuer acting as an utilization review organization or the independent review organization has either:

(1) Used such method or practice that constitute an unfair trade practice, pursuant to Part IV of Chapter 7 of this Title, R.S. 22:1961 et seq., or that such conduct of its business renders determinations in this state made pursuant to this Chapter hazardous or injurious to covered persons or the public.

(2) Failed to comply with any provision of this Chapter.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

E. Whenever the commissioner believes, from evidence satisfactory to him, that any utilization review organization, health insurance issuer acting as a utilization review organization, or independent review organization is violating or is about to violate any provision of this Chapter or any order or requirement of the commissioner issued or promulgated pursuant to authority granted to the commissioner by any provision of this Code or by law, he may bring an action in the District Court for the Nineteenth Judicial District, Baton Rouge, Louisiana, against such utilization review organization, health insurance issuer acting as a utilization review organization, or independent review organization to enjoin such utilization review organization, health insurance issuer acting as a utilization review organization, or independent review organization from continuing such violation or engaging therein or doing any act in furtherance thereof. In any such action, an order or judgment may be entered awarding such preliminary or final injunction as is proper.

Added by Acts 2013, No. 326, § 1, eff. Jan. 1, 2015.