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Title 37
INSURANCE
Part I. Risk Management
Subpart 1. Insurance and Related Matters

Chapter 1. Underwriting

§101. Underwriting

A. All coverages which are self-insured by the Office of Risk Management are mandatory for all Louisiana state departments, agencies, boards, and commissions.

B. If any department, agency, board, or commission requires or wishes to procure any insurance coverages which are not written through the Louisiana Self Insurance Program, request is to be made to the Office of Risk Management to procure said coverage. It is the responsibility of the department, agency, board, or commission to provide the underwriting information required to procure or underwrite the risk.

C. All leases for real and movable property (including vehicles) which are entered into by any state department, agency, board, or commission are to be forwarded to the Office of Risk Management for review in compliance of insurance requirements.

D. All inquiries regarding interpretation of insurance coverages are to be addressed to the underwriting unit and are to be in a written form.

E. Boiler and machinery equipment at new locations are to be reported to the underwriting unit.

F. Builder's risk projects are to be reported to the underwriting unit when the construction contract has been awarded or the "Notice to Proceed" has been issued.

G. All newly constructed state-owned buildings are to be reported to the underwriting unit upon acceptance/completion.

H. All newly acquired state-owned aircraft are to be reported to the underwriting unit immediately but in no event more than 30 days after acquisition. All newly leased or borrowed aircraft are to be reported to the underwriting unit immediately but in no event more than 30 days after possession or lease.

I. Any newly acquired, constructed, leased, or borrowed airport or heliport facilities are to be reported to the underwriting unit before coverage will be effective.

J. All newly acquired state-owned marine vessels which are over 26 feet in length are to be reported to the underwriting unit immediately but in no event more than 30 days after acquisition. All newly leased or borrowed marine vessels which are over 26 feet in length are to be reported to the underwriting unit immediately but in no event more than 30 days after possession or lease.

K. Applications for new crime policies are to be submitted to the underwriting unit. Coverage does not become effective until the insurance company has accepted the new risk.

L. All departments, agencies, boards, and commissions are to provide the name, address, telephone number, and job title of the following:

1. the department, agency, board, or commission head;

2. the person(s) to receive insurance premium billings;

3. the safety coordinator or person(s) responsible for loss prevention matters;

4. the person(s) responsible for handling and disposition of claims matters;

5. the person(s) responsible for reporting exposure information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:19 (January 1987), amended LR 31:61 (January 2005), LR 32:1435 (August 2006).

Chapter 3. Auditing and Statistics

§301. Auditing and Statistics

A. The exposure data requested by the Office of Risk Management (ORM) are to be submitted in a timely manner and in the form specified. The exposures may include, but are not limited to:

1. payroll;

2. maritime payroll;

3. number of board and commission members;

4. mileage of all licensed vehicles which are state-owned or leased, and all mileage on personal vehicles driven in the course and scope of state employment;

5. number of licensed vehicles;

6. acquisition or appraised value of property including, but not limited to, buildings, improvements, and inventory (includes contents, all equipment including mobile equipment and watercraft 26 feet and under), and boiler and machinery;

7. medical malpractice exposures including, but not limited to, patient days, clinic visits, emergency room visits, number of residents/ interns, and miscellaneous categories;

8. number of employees, and miscellaneous or special classes not falling within these definitions as required.

B. Billed units are to allocate premiums to subunits if required. It is not the ORM's responsibility to provide breakdowns at a lower level than the level to which premiums were budgeted or billed.

C. The Office of Risk Management is to receive immediate written notification of the abolishment, transfer, and/or merger of any department, agency, board or commission.

D. The state agencies are to provide or allow access to ORM representatives to records or information necessary to the effective operation of the risk management program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:19 (January 1987), amended LR 15:85 (February 1989), LR 31:62 (January 2005), LR 32:1436 (August 2006).

Chapter 5. Billing

§501. Billing and Collection of Insurance Premiums

A. After an agency receives a billing invoice from the Office of Risk Management for payment of insurance premiums, the agency is to render payment in full within 30 days from the billing date.

B. Every agency shall timely pay premiums billed by the Office of Risk Management. In the event any agency fails to pay any premiums due the Office of Risk Management within 120 days of the effective date of the appropriated insurance coverages, the commissioner of administration may upon request by the Office of Risk Management draw a warrant against budgeted funds of any delinquent agency directing the treasurer to pay the Office of Risk Management for the unpaid premiums. If an agency is a non-depository agency, the commissioner of administration may direct the head of such agency to render payment of insurance premiums due and owing to the Office of Risk Management.

C. All billing inquiries are to be directed to the Office of Risk Management, Accounting Unit, Accounts Receivable Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:20 (January 1987), amended LR 31:62 (January 2005), LR 32:1436 (August 2006).

Chapter 7. Reporting of Claims

§701. Reporting of Property Damage Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states…"you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance coverage for damage to state-owned property which includes damage to buildings and improvements, contents, inventories, mobile equipment, heating and air conditioning systems, and marine hulls 26 feet and under.

C. All claims for damage to property owned by the state are to be reported to the Office of Risk Management's Property Claim Unit in writing. If a loss or claim is serious in nature, it is to be reported by telephone to the Office of Risk Management's Property Claim Unit.

D. Claims are to be submitted, in writing, to the Office of Risk Management, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E. Information required to be submitted when a claim is reported to the Office of Risk Management's Property Claim Unit includes the following:

1. name of insured, location of property or unit;

2. date of loss;

3. description of loss;

4. location of item, state building ID/property control tag number;

5. size, model, and serial number of item, if applicable;

6. name of person reporting claim, listing job title, and telephone number; and

7. proof of ownership.

F. After a loss has occurred, all property which has been damaged is to be protected against further damage and is to be made available for inspection by a claims adjuster assigned by the Office of Risk Management.

G. If a loss occurs or a claim arises, the agency is not to assume any obligation or incur any expenses without authorization from the Office of Risk Management, but should act to protect property and minimize the loss.

H. If repair or replacement is not accomplished within 36 months of the loss date; or, if approval is not obtained from the commissioner of administration to use the funds for some other purpose, or to extend the 36 month prescriptive period, the claim file will be closed.

I. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management, Property Claims Unit for further handling.

J. Any objects and/or products which may have caused, contributed to, or which are suspective of causing an accident are to be retained and preserved as evidence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:20 (January 1987), amended LR 15:85 (February 1989), LR 31:62 (January 2005), LR 32:1436 (August 2006).

§703. Reporting of Boiler and Machinery Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance coverage for bodily injury and third party property damage claims where such losses result from state-owned boiler and machinery equipment, and for property damage to state-owned boiler and machinery equipment.

C. All claims for damage to boiler and machinery equipment are to be reported to the Office of Risk Management's Property Claim Unit in writing. Any claim involving bodily injury is to be reported by telephone to the Office of Risk Management's Property Claims Unit.

D. Claims are to be submitted in writing to the Office of Risk Management, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E. Information required to be submitted when a claim is reported to the Office of Risk Management's Property Claim Unit includes the following:

1. name of insured, location of property or unit;

2. date of loss;

3. description of item, to include size, model, serial number, and tonnage or capacity;

4. name, job title, and telephone number of person reporting claim;

5. name and phone number of person to be contacted by adjuster assigned by ORM.

F. After a loss has occurred, the property which has been damaged is to be protected against further damage and is to be made available for inspection by a claims adjuster.

G. If replacement, repair, reconstruction, or rebuilding is not commenced within 36 months of the loss date for all state property losses; or if a claim remains inactive for 36 months after replacement, repair, reconstruction or rebuilding is commenced; or if approval is not obtained from the commissioner of administration within the same period of time for expenditure of insurance proceeds for some other purpose, the claim file will be closed.

H. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management's Property Claim Unit for further handling.

I. Any objects and/or products which may have caused, contributed to, or which are suspective of causing an accident are to be retained and preserved as evidence.

AUTHORITY NOTE: Promulgated in accordance with R. S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:20 (January 1987) amended LR 15:85 (February 1989), LR 31:63 (January 2005), LR 32:1437 (August 2006).

§705. Reporting of Comprehensive General Liability Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides comprehensive general liability coverage for bodily injury and property damage claims resulting from operations for which the agency could be held legally liable.

C. All general liability claims are to be submitted, in writing, to the Office of Risk Management on a General Liability Claim Reporting Form or in a narrative format. The General Liability Claim Reporting Form can be found on the Office of Risk Management's web site, www.doa.louisiana.gov/orm.

D. Claims are to be submitted, in writing, to the Office of Risk Management, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E. If a loss is serious in nature, it is to be reported by telephone to the Office of Risk Management for review to determine if coverage is applicable.

F. Claims which are made against a state agency by a third party are to be submitted to the Office of Risk Management for review to determine if coverage is applicable.

G. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management's Claim Office for further handling.

H. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be removed from service, retained and preserved as evidence.

I. If a loss occurs or a claim arises the agency is not to assume any obligation or incur any expenses without authority from the Office of Risk Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:20 (January 1987), amended LR 15:85 (February 1989), LR 31:63 (January 2005), LR 32:1437 (August 2006).

§707. Reporting of Worker's Compensation and Maritime Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance coverage for worker's compensation and maritime claims.

C. All accidents or occupational diseases involving state employees while in the course and scope of their employment with the state are to be reported to the Office of Risk Management within five days from the date of injury or knowledge. The forms used for this purpose are the Employer's Report of Occupational Injury or Disease Form (E-1, completed at the time of the accident), and the Pre-Existing Condition Form (E-2, which was completed when hired). The Office of Risk Management will accept electronic filing of the Employer's Report of Occupational Injury or Disease Form. Access www.doa.louisiana.gov/orm and click on Agency Claims Reporting System.

D. Employer's Report of Occupational Injury or Disease Forms can be obtained from the Office of Risk Management's web address cited in the above paragraph. The Pre-Existing Condition Form can be obtained from the Office of Risk Management, Claims Section, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E. A copy of the Employer's Report of Occupational Injury or Disease Form and a copy of the Pre-Existing Condition Form for a claim in which lost time exceeds seven days, is to be submitted to the Office of Worker's Compensation Administration, P.O. Box 94040, Baton Rouge, LA 70804-9040 within 10 days of actual knowledge of injury or death.

F. All Employer's Report of Occupational Injury or Disease Forms and Pre-existing Condition Forms are to be accurately and completely filled out.

G. Information required to be submitted when a worker's compensation claim is reported on the Employer's Report of Occupational Injury or Disease Form includes:

1. agency's location code number (located in a block below the Employer's Federal Tax I.D. Number);

2. the occupation of the employee, inclusive of his/her classified or unclassified job title. A classified job title is to include the civil service job classification code number;

3. an injured employee's weekly wages are to be reported on the Employer's Report of Occupational Injury or Disease Form.

H. Information which is to be contained on the Preexisting Condition Form includes:

1. complete name, age, Social Security number, residential address, and civil service position being applied for;

2. check list of possible pre-existing diseases, disabilities, and/or conditions before employment;

3. description of particulars relative to any checked pre-existing permanent disabilities;

4. name and address of employer at time of previous injury;

5. witnessed and dated signature of applicant as to the completeness, accuracy, and validity of the information contained on the Pre-Existing Condition Form.

I. If an injured employee returns to work after having lost time, the Office of Risk Management, Worker's Compensation Claims Unit, is to be notified immediately by telephone or electronic mail, and an Employer's Supplemental Report of Injury is to be submitted confirming the return to work date. Also, an Employer's Supplemental Report of Injury Form is to be submitted to the Office of Risk Management at any time the injured employee's work status changes.

J. All lawsuits, demands, notices, summons, or other legal documents pertaining to claims are to be forwarded immediately to the Office of Risk Management's Claim Office for further handling.

K. Any objects and/or products which may have caused, contributed to, or which are suspected of causing any accident are to be retained and preserved as evidence.

L. Any claim paid by legislative appropriation is to be reported to the Office of Risk Management by Appropriations Control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:21 (January 1987) amended LR 15:85 (February 1989), LR 16:401 (May 1990), LR 31:64 (January 2005), LR 32:1438 (August 2006).

§709. Reporting of State Automobile Liability and Physical Damage Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only

for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance coverage for liability and physical damage to state-owned and leased licensed vehicles and excess liability coverage for employee's private automobiles while being operated with proper authorization during the course and scope of state employment.

C. All claims for liability or physical damage to state-owned and leased licensed vehicles are to be reported to the Office of Risk Management's Transportation Claims Unit in writing. If a loss involves property damage estimated at $5,000 or more or if a loss involves any bodily injury, the loss is to be reported by telephone to the Office of Risk Management Transportation Claims Unit.

D. All claims are to be submitted to the Office of Risk Management, Transportation Unit, P.O. Box 91106, Baton Rouge, LA 70821-9106 on a DA 2041 (revised 12/98) accident report form. This form must be completed within 48 hours after an automobile accident. These forms are available through DOA/Forms Management and the Office of Risk Management's web site, www.doa.louisiana.gov/orm.

E. The Automobile Accident Form (DA 2041) must be completed and submitted to the Office of Risk Management, Transportation Unit, P.O. Box 91106, Baton Rouge, LA 70821-9106 or faxed to (225) 342-4470 within 48 hours after the accident occurred.

F. Automobile accident reports are to be submitted with as much information as possible; however, if certain information is unavailable, the report is to still be submitted. Information which is unavailable can be obtained at a later date.

G. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be submitted immediately to the Office of Risk Management's Claim Office for further handling.

H. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be retained and preserved as evidence.

I. If a loss occurs or a claim arises, do not assume any obligation or incur any expenses without authority from the Office of Risk Management.

J. If repair or replacement of a state vehicle is not completed within 12 months of the loss date, or if approval is not obtained from the commission of administration within the same period of time for expenditure of insurance proceeds for some other purpose, the claim file will be closed.

K. More information relative to the reporting of state automobile liability and physical damage claims such as reimbursement of collision deductible on employees' personally-owned vehicle used on state business, towing of state vehicles, reduction of automobile liability limit in a special circumstance, rented motor vehicles and/or courtesy vehicles, and guidelines for in-house repairs to state owned licensed vehicles can be found on the Office of Risk Management's web site, www.doa.louisiana.gov/orm.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:21 (January 1987) amended LR 15:85 (February 1989), LR 31:65 (January 2005), LR 32:1438 (August 2006).

§711. Reporting of Aviation Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance coverage for aviation losses which includes liability and hull coverage. All claims are to be reported to the Office of Risk Management's Transportation Claims Unit.

C. Claims are to be submitted within 48 hours after an accident/incident to the Office of Risk Management, Transportation Unit, P.O. Box 91106, Baton Rouge, LA 70821-9106 on the Aviation Accident Report form furnished by the Office of Risk Management. Please contact the transportation unit supervisor for these forms.

D. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management's Transportation Claims Unit for further handling.

E. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be retained and preserved as evidence.

F. If a loss occurs or a claim arises, the agency is not to assume any obligations or incur any expenses without authority from the Office of Risk Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:21 (January 1987) amended LR 15:85 (February 1989), LR 31:65 (January 2005), LR 32:1438 (August 2006).

§713. Reporting of Wet Marine Claims (Over 26 Feet)

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance for liability and hull damage for marine vessels over 26 feet in length.

C. All claims involving vessels in excess of 26 feet are to be reported, in writing, to the Office of Risk Management's Transportation Unit. All bodily injury claims are to be reported by telephone to the Office of Risk Management's Transportation Unit.

D. Claims are to be submitted in writing within 48 hours after an accident/incident to the Office of Risk Management, Transportation Unit, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E.1. Information required to be submitted when a claim is reported to the Office of Risk Management's Transportation Unit includes the following:

a. complete description of vessel, including hull identification and coast guard certificate number;

b. name of captain or master and passengers;

c. exact location of incident;

d. date and time of incident;

e. names and addresses of third parties involved if known;

f. description of damages;

g. contact persons who can assist in investigation;

h. circumstances surrounding and/or cause of accident.

2. All accidents/incidents involving ferry boats are to be reported to the Office of Risk Management on the Department of Transportation (DOTD) accident report forms: DOTD 03-18-3023 for private vehicles and DOTD 03-18-3024 for passenger(s) injured.

F. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management's Transportation Claims Unit for further handling.

G. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be retained and preserved as evidence.

H. If a loss occurs or a claim arises, the agency is not to assume any obligation or incur any expenses without authority from the Office of Risk Management.

I. Refer to the Office of Risk Management's web site, www.doa.louisiana.gov/orm, for procedures for repairing water vessels (over 26 feet) covered by the commercial insurance market.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:21 (January 1987), amended LR 15:85 (February 1989), LR 31:65 (January 2005), LR 32:1439 (August 2006).

§715. Reporting of Bond and Crime Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides insurance coverage for bond and crime which includes performance, money and securities. All claims are to be reported, in writing, to the Office of Risk Management's Property Claims Unit, P.O. Box 91106, Baton Rouge, LA 70821-9106.

C. Information required to be submitted includes the following:

1. name of insured agency;

2. date of loss;

3. location of loss;

4. circumstances surrounding the occurrence;

5. approximate value of loss; and

6. name of person reporting claim, listing job title and telephone number.

D. Claims are to be submitted, in writing, to the Office of Risk Management, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be retained and preserved as evidence.

F. If a loss occurs or a claim arises, the agency is not to assume any obligation or incur any expenses without authority from the Office of Risk Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:22 (January 1987), amended LR 15:85 (February 1989), LR 31:66 (January 2005), LR 32:1440 (August 2006).

§717. Reporting of Medical Malpractice Liability Claims

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. Prior to July 1, 1988 the state of Louisiana provided medical malpractice coverage in accordance with the provision of R.S. 40:1299.39 which details coverage and liability provisions. Effective July 1, 1988, the state of Louisiana became self-insured for medical malpractice. Medical malpractice coverage is extended to state health care facilities and individuals acting in a professional capacity in providing health care services by or on behalf of the state, including medical, surgical, dental, or nursery treatment of patients.

C. Coverage excludes the following:

1. premises liability;

2. bodily injury to employees arising out of employment by the insured;

3. all obligations under worker's compensation or similar laws; and

4. bodily injury in handling or maintenance of automobiles, aircraft, watercraft, or transportation of mobile equipment by an auto owned, operated, rented, or loaned to any insured.

D. Claims are to be submitted, in writing, to the Office of Risk Management, P. O. Box 91106, Baton Rouge, LA 70821-9106.

E. If a loss is serious in nature, it is to be reported by telephone to the Office of Risk Management for review to determine if coverage is applicable.

F. Claims which are made against a state agency by a third party are to be submitted to the Office of Risk Management for review to determine if coverage is applicable.

G. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management's Medical Malpractice Claim Unit for further handling.

H. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be retained and preserved as evidence.

I. If a loss occurs or a claim arises, the agency is not to assume any obligation or incur any expenses without authority from the Office of Risk Management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 13:22 (January 1987), amended LR 15:85 (February 1989), LR 31:66 (January 2005), LR 32:1440 (August 2006).

§719. Reporting of Road and Bridge Hazard Claims (Department of Transportation and Development)

A. All claims must be reported as soon as possible, but no later than the prescription period outlined in Book III, Title 24, Chapter 4 of the Louisiana Civil Code. In most cases, prescription periods are one year. ORM will pay only for covered losses reported before one year from the date of the accident or discovery date. Policy language clearly states: "…you must see to it that we are notified as soon as practicable of an 'occurrence' or an offense which may result in a claim." Failure to report potential claims as soon as possible severely limits the ability of ORM to investigate the facts and may compromise the state's legal rights to subrogation from a responsible third party.

B. The state of Louisiana provides road and bridge hazard liability coverage for bodily injury and property damage claims resulting from the establishment, design, construction, existence, ownership, maintenance, use, extension, improvement, repair, or regulation of any state bridge, tunnel, dam, street, road, highway, or expressway for which the agency could be held legally liable.

C. All road and bridge hazard claims are to be submitted, in writing, to the Office of Risk Management on the DOTD/ORM Report of Road Hazard Incident form. Forms can be obtained from the Office of Risk Management's Road and Bridge Hazard Claims Unit or on the ORM web site, www.doa.louisiana.gov/orm.

D. Claims are to be submitted, in writing, to the Office of Risk Management, P.O. Box 91106, Baton Rouge, LA 70821-9106.

E. If a loss is serious in nature, it is to be reported by telephone to the Office of Risk Management for review to determine if coverage is applicable.

F. Claims which are made against a state agency by a third party are to be submitted to the Office of Risk Management for review to determine if coverage is applicable.

G. All lawsuits, demands, notices, summons, or other legal documents pertaining to a claim against a state agency are to be forwarded immediately to the Office of Risk Management's Claim Office for further handling.

H. Any objects and/or products which may have caused, contributed to, or which are suspected of causing an accident are to be retained and preserved as evidence.

I. If a loss or a claim arises, the agency is not to assume any obligation or incur any expenses without authority from the Office of Risk Management.

J. It would be the responsibility of the district office of the Department of Transportation and Development to verify the following:

1. that the alleged accident occurred on a state maintained highway/road;

2. existence of the damage;

3. whether the state had knowledge of the defect prior to the alleged accident;

4. the existence of any contract which may exist between the state and any municipality, contractor or other party.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of the Governor, Division of Administration, Office of Risk Management, LR 15:85 (February 1989), amended LR 31:67 (January 2005), LR 32:1441 (August 2006).

§721. Claims Unit Contacts

A. For further information on reporting a claim or requesting information regarding a specific claim, contact the Office of Risk Management, in writing, at P.O. Box 91106, Capitol Station, Baton Rouge, LA 70821-9106 or telephone the appropriate claims unit.

Unit	Contact the following Telephone Number(s)
Claims-Administrative	(225) 219-0012 or (225) 219-0168
Property	(225) 342-8399
1. Buildings and Improvements. Contents and equipment, excluding boiler and machinery. 2. Boiler and Machinery 3. Bonds and Crime	
Transportation	(225) 342-8466
1. Auto Liability 2. Automobile Comprehensive and Collision 3. Aviation 4. Wet Marine	
General Liability-All Comprehensive General Liability	(225) 342-8463
Medical Malpractice	(225) 342-8442 (225) 219-0868
Workers' Compensation	(225) 342-7390 or (225) 342-8451 or (225) 342-8458 or (318) 487-5411
1. Statutory and Employer's Liability 2. Maritime Compensation	
Road and Bridge Hazards-All Road and Bridge Hazards	(225) 342-5441 or (225) 219-4846
Subrogation	(225) 342-8446

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 15:86 (February 1989), amended LR 31:67 (January 2005), LR 32:1441 (August 2006).

Chapter 9. Risk Analysis and Loss Prevention

§901. Risk Analysis and Loss Prevention

A. R.S. 39:1543 requires the development of a comprehensive loss prevention program, for implementation by all state agencies, including basic guidelines and standards of measurement.

B. In order to fully comply with this statute a comprehensive loss prevention plan has been developed, and the following are to be implemented by every state department, agency, board, or commission that employs 15 or more employees.

Any Other Loss Prevention Program—developed by the Office of Risk Management, Loss Prevention Unit in conjunction with the Interagency Advisory Council for the prevention and reduction in accident events that may cause injury, illness, or property damage.

Aviation Safety Program—program to provide a systematic method of screening, training, and accountability for employees and supervisors required to assign or operate state-owned aircraft in the scope of their employment.

Driver Safety Program—program to provide a systematic method of screening, training, and accountability for employees and supervisors required to assign or drive state-owned vehicles or personal vehicles in the course and scope of their employment.

Employee Training—training to establish a systematic method of training employees to perform the required tasks in a safe and efficient manner and to insure all employees receive periodic refresher training.

Equipment Management Program—written loss prevention maintenance program to include, but not limited to, a history of each piece of equipment, designate responsibility, schedule of when maintenance is to be performed, list of equipment to be maintained, how maintenance is to be performed.

First Aid—adoption of a first aid program which will provide a trained first aid person at each job site and shift. This policy covers all facilities and crews.

Hazard Control Program—program to establish a systematic method of recognizing, evaluating, and controlling hazards prior to them producing injury, illness, or property damage.

Housekeeping Program—program to provide a method for systematically inspecting and eliminating safety and fire hazards that result from uncontrolled sources. To establish clearly defined areas of responsibility for orderliness and cleanliness through each state-owned or operated grounds and facilities.

Inspections Program—a program to maintain a safe environment and control unsafe acts, roadway hazard inspection reports, and medical malpractice records.

Investigation Program—a program to thoroughly investigate and identify, as soon as possible, the actual causes and contributing factors of losses in an attempt to prevent recurrences.

Job Safety Analysis—a procedure to be used to review job methods and hazards that relate to the work environment. The job safety analysis should be performed on all tasks or processes that have a higher than normal rate of producing bodily injury or property damage.

Management Policy Statement—an expression of management, philosophies and goals toward safety.

Record Keeping—records to establish a procedure for the uniform development and maintenance of loss prevention and control documents to be retained for one year. This will include inspection reports, accident investigation reports, minutes of safety meetings, training records, boiler and machinery maintenance records, and/or conditions by regular and periodic facility equipment and roadway inspections.

Responsibility for Safety in an Organization—a written document to clearly define supervisory responsibilities at all levels.

Safety Meetings—meetings to be conducted by supervisors with employees on a quarterly basis, unless otherwise specified by ORM, to educate, inform, motivate and examine work practices for potentially unsafe acts that could produce bodily injury and provide a method to preclude recurrences.

Safety Rules—general instructions developed by agencies regarding the employees' responsibilities.

Water Vessel Operator Safety Program—program to provide a systematic method of screening, training, and accountability for employees and supervisors required to assign or operate state-owned water vessels in the scope of their employment.

C. The minimum requirements are in no way intended to require revisions of existing safety plans which meet or exceed these minimum requirements. However, these existing plans are subject to the loss prevention unit for review and acceptance.

D. The loss prevention unit will audit each department, agency, board, or commission to insure compliance of the development, implementation, and adherence to the program. Audits will be conducted once every three years with a re-certification review performed in subsequent years. The deadline for certification will be April 30 of each year for insurance premiums for the following fiscal year. Any agency, board or commission found to be in compliance with state law and loss prevention standards prescribed by the Office of Risk Management shall receive a credit to be applied to the agency's annual self-insured premium per line of insurance coverage, excluding the coverages for road hazards and medical malpractice, equal to 5 percent of the agency's total annual self-insured premium paid per line of coverage. An agency which has failed to receive certification after undergoing a loss prevention audit shall be liable for a penalty of 5 percent of the agency's total annual self-insured premium paid per line of coverage, excluding the coverages for road hazards and medical malpractice. Such compliance will be certified by major risk groups as follows:

1. workers compensation—regular;
2. workers compensation—maritime;
3. general liability;
4. auto liability and auto physical damage;
5. property and inland marine;
6. boiler and machinery;
7. bond and crime risk;
8. aviation;
9. marine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 14:349 (June 1988), amended LR 15:86 (February 1989), LR 31:68 (January 2005), LR 32:1442 (August 2006).

Chapter 11. Law Enforcement Officers' and Firemen's Survivor Benefit Review Board

§1101. Survivors Benefits

A. Purpose

1. To establish an effective and efficient mechanism for fulfilling the provisions of R.S. 39:1533.A, 33:1981, 33:1947, and 33:2201.B.

2. To govern the submission, evaluation and determination of claims submitted pursuant to R.S. 33:1947, 33:2201, and 33:1981.

B. Application

1. The rules will apply to all claims arising from R.S. 33:1947, 33:2201, and 33:1981.

C. Definitions

Board—the Law Enforcement Officers and Firemen's Survivors Benefit Board.

Child—as defined in R.S. 33:1947.C.

Fireman—as defined in R.S. 33:1981.

Law Enforcement Officer—as defined in R.S. 33:2201.B.

Line of Duty—any activity performed in which a law enforcement officer suffers death as a result of:

a. an injury arising out of and in the course of the performance of his official duties; or

b. arising out of any activity while on or off duty, in his official enforcement capacity, involving the protection of life or property.

Qualifying Claim—those claims meeting the criteria of claims request documentation, and the meaning ascribed to line of duty.

Spouse—as defined in R.S. 33:1947.C.

D. Board Membership and Domicile

1. The board's official domicile will be located in Baton Rouge. All claims hearings, presentations etc. will be held in the board's official domicile. Claimant expenses related to claim preparation and presentation are not allowable for reimbursement. Board members serve on a gratuitous basis. The chairman of the board shall be on a rotation basis as follows: attorney general, legislative auditor, and state risk director. The term of each chairman is limited to two years. The attorney general's term shall begin effective September 19, 1989.

2. The board will be comprised of those individuals or their designees as stated in R.S. 33:1947.

E. Claims Requests

1. All claims shall be submitted to the chairman of Louisiana Law Enforcement and Firemen's Survivors Benefit Board through the Department of Justice-Attorney General.

2. All claim requests must include the following documentation:

a. notarized affidavit for decedent's date of employment, rank, duty assignment, routine work schedule, work responsibilities, brief statement outlining injuries;

b. copy of decedent's commission as police officer/fireman;

c. notarized affidavits from any witnesses to incident;

d. certified copy of investigative report, or uncertified copy accompanied by notarized affidavit of reporting investigative officer, which identifies copy of report as accurate reproduction of original report;

e. certified copy of decedent's death certificate and autopsy protocol report;

f. notarized affidavit from decedent's surviving spouse stating full their full name, address, date of marriage, and that they were not legally separated or divorced at time of death. Also, a certified copy of marriage license;

g. list of names and birth dates of each minor child born to or adopted by decedent, certified copies of birth certificates;

h. certified copy of letters of tutorship;

i. notarized affidavit of tutor or legal representative of surviving child stating child is unmarried and under the age of 18, or alternately, is unmarried, under the age of 23, and a student;

j. notarized affidavit of caretaker of surviving child which states the major child is physically and/or mentally handicapped, totally and permanently disabled, and solely dependent upon decedent for support. Also, copy of the major child's medical and /or psychological records; and

k. if decedent was not survived by a spouse, a notarized affidavit from parents which state that decedent was their child, the date and place of decedent's birth, and full name and address of each surviving parent. Also, a copy of decedent's birth certificate or other legal documents which indicate the name(s) of parent(s).

F. Procedures for Hearings

1. Upon receipt of a claim, the chairman will schedule the claim for board hearing within 60 days after all required documentation is received. Each claim shall be assigned a sequential number claim code which shall be utilized for official references.

2. The chairman shall notify the board members, claimant, and appointing authority of the claimant of the claim items up for consideration no later than 10 days prior to hearing.

3. At the hearing date described the board shall officially receive and act upon all claims received.

4. The board may, at its discretion, entertain additional oral presentations from outside parties regarding the claim.

5. The board shall have the following options with regards to the claim action:

a. approval of the qualifying claim;

b. denial of the claim;

c. deferral pending receipt of additional data.

6. The board shall inform the claimant, in writing, of its determination.

7. If approved, the board chairman shall certify to the commissioner of administration and request payment in accordance with R.S. 39:1533.

G. Appeals

1. Claimant may appeal within 60 days of being advised of the board's decision;

2. This appeal shall be filed in the 19th JDC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:1947, R.S. 33:1981, R.S. 33:2201, and R.S. 39:1533.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Risk Management, LR 16:400 (May 1990), amended LR 31:69 (January 2005), LR 32:1443 (August 2006).

Title 37
INSURANCE
Part I. Risk Management
Subpart 2. Worker's Compensation Fee Schedule

Chapter 25. Fees

§2501. Fee Schedule

A. The director, Office of Risk Management, Division of Administration, pursuant to notice of intent published December 20, 1987, and pursuant to provisions of R.S. 23:1034.2 and R.S. 39:1527 et seq., adopted effective April 1, 1988 a fee schedule for medical, surgical, and hospital services due under the Louisiana Worker's Compensation Act, R.S. 23:1021-1361, and which arise in the state self-insured worker's compensation cases. Effective, July 1, 1994, the Office of Risk Management began utilizing the medical fee schedule promulgated by the Office of Workers' Compensation in accordance with R.S. 23:1034.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1527 et seq.

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Risk Management, LR 14:148 (March 1988), amended LR 16:401 (May 1990), LR 31:69 (January 2005), LR 32:1444 (August 2006).

Title 37
INSURANCE
Part III. Patients' Compensation Fund Oversight Board

Chapter 1. General Provisions

§101. Scope

A. The rules of Part III provide for and govern the organization, administration, and defense of the Patients' Compensation Fund (the fund or PCF) by the Louisiana Patients' Compensation Fund Oversight Board (the board), within the Office of the Governor; the requirements and procedures for enrollment with the fund by qualified health care providers; the maintenance of required financial responsibility and continuing enrollment with the fund by enrolled health care providers; record keeping, accounting, and reporting of claims and claims data by the fund and enrolled health care providers; and defense of the fund and the payment of judgments, settlements and arbitration awards by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§103. Source and Authority

A. These rules are promulgated by the board to provide for and implement its authority and responsibility to administer and defend the Patients' Compensation Fund pursuant to the Louisiana Medical Malpractice Act (the Act), R.S. 40:1299.41-1299.48.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§105. Patients' Compensation Fund: Description

A. The Patients' Compensation Fund is a special fund established by R.S. 40:1299.44, funded by surcharges paid by private health care providers enrolled with the fund, to provide just compensation to patients suffering loss, damages, or expense as the result of professional malpractice in the provision of health care by health care providers enrolled with the fund, when and to the extent that a judgment or settlement or a final award in an arbitration proceeding is in excess of the total liability of all liable health care providers, as provided by and subject to the limitations of R.S. 40:1299.42. Such fund, therefore, comprises monies held in trust as a custodial fund by the state for the use, benefit, and protection of medical malpractice claimants and the fund's private health care provider members. Responsibility and authority for administration and operation of the fund including, but not limited to, the evaluating, establishing reserves against, defending, and settling claims against the fund, applying to the Louisiana Insurance Rating Commission, on the basis of annual actuarial studies, for surcharge rates or rate changes, and administering medical review panel proceedings under R.S. 40:1299.47, is vested in the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§107. Purpose and Objective of Rules; Construction, Application

A. These rules are adopted and promulgated to ensure that the Patients' Compensation Fund is organized, administered, and operated on a financially and actuarially sound basis so as to achieve the purpose for which it was established, by providing that qualification for enrollment is based on sound and realistic standards of financial responsibility; that the fund and its surcharge rates are adequate for the risks assumed; that surcharges are timely collected; that surcharge rate filings are based on reasonably current and complete claims experience data; that actual and potential claims against the fund are timely reported; that reserves against claims are properly established; that the fund is properly defended against improper, unjustified, and excessive claims; and that the fund is responsible and accountable to the patients for whose benefit it exists and to its enrolled health care providers. These rules shall be construed, interpreted, and applied so as to achieve such purposes and objectives.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:167 (February 1992).

§109. General Definitions

A. As used in these rules, the following terms shall have the meanings specified:

1. Terminology Definitions

Act—the Louisiana Medical Malpractice Act, Act 1975, Number 817, as amended, R.S. 40:1299.41-1299.48.

Board—the Louisiana Patients' Compensation Fund Oversight Board established pursuant to R.S. 40:1299.44 .D.

Executive Director—the Executive Director of the Louisiana Patients' Compensation Fund Oversight Board, as designated, appointed, and delegated authority pursuant to §303.

2. Coverage Definitions

Claims-Made Coverage—a form of professional liability coverage which provides coverage for a claim arising from an incident which both occurred and was reported during the effective period of qualification with the fund. Provider must meet all requirements for continued qualification.

Extended Reporting Endorsement—tail coverage.

Occurrence Coverage—a form of professional liability coverage which provides coverage for a claim arising from an incident which occurred during the effective period of qualification, regardless of whether the provider was actively enrolled on the date on which the claim was reported. Provider must meet all requirements for continued qualification.

Self-Insured Coverage—a form of professional liability coverage which provides coverage for a claim arising from an incident which occurred during the effective period of qualification, regardless of whether the provider was actively enrolled on the date on which the claim was reported. Provider must meet all requirements for continued qualification.

Tail Coverage—an endorsement which, when purchased by a provider at the end of his claims-made coverage period, provides coverage for a claim arising from an incident which occurred during the effective period of enrollment but was reported following the termination of active enrollment. Provider must meet all requirements for continued qualification.

3. Provider Definitions

Enrolled Provider—an enrolled provider is one who has met the requirements for qualification in the Louisiana Patients' Compensation Fund (including the financial responsibility requirements of R.S. 40:1299.42) who also:

i. is currently actively involved in medical practice and/or providing medical services in Louisiana; and

ii. has paid the appropriate surcharge for such practice to the fund for their current policy year.

Qualified Provider—any provider who has met the statutory requirements for malpractice coverage with the Louisiana Patients' Compensation Fund. Qualified providers may be currently either active or inactive in the practice of medicine in Louisiana, depending on the dates for which they are qualified. So long as the financial responsibility requirements for continued qualification are met, a provider need not be currently enrolled in the PCF.

4. General Definitions

Accept or *Collect*—with reference to the acceptance or collection of payments of applicable surcharges for enrollment with the fund, such surcharges will be deemed to have been *accepted* or *collected* by the commercial professional health care liability insurance companies and approved self-insurance trust funds when the first agent, employee, representative, or other person acting or purporting to act on behalf of the insurer or the trust fund who has the responsibility to process such surcharges accepts delivery of same.

Disability—for purposes of determining eligibility for the provisions of §715.D of these rules, the inability to continue the practice of medicine due to a permanent illness, injury, or physical impairment. However, for purposes of consideration for a waiver under the provisions of §715.C.3 of these rules, *disability* may also include any permanent illness, injury, or physical impairment which prevents a provider from continuing the practice of his existing medical specialty, surgical class, or risk rating classification as provided in §705 of these rules, whether or not such disability prevents the provider from engaging in the active practice of medicine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:168 (February 1992), amended LR 23:68 (January 1997), LR 29:344 (March 2003).

§111. Interpretive Definitions

A. As used in these rules and in the Act, the following terms are interpreted and deemed to have the meanings specified.

Certified Nurse Assistant—a certified nurse aide certified by the Board of Examiners of Nursing Facility Administrators, pursuant to R.S. 37:2504, as amended.

Certified Registered Nurse Anesthetist—a registered nurse who administers any form of anesthetic to any person in Louisiana in accordance with the conditions specified by R.S. 37:930, as amended.

Chiropractor—a person holding a license to engage in the practice of chiropractic in the state of Louisiana, pursuant to R.S. 37:2801-2830, as amended.

Dentist—a person holding a license to engage in the practice of dentistry in the state of Louisiana, pursuant to R.S. 37:751-793, as amended.

Licensed Practical Nurse—a person holding a license to engage in the practice of practical nursing in the state of Louisiana, pursuant to R.S. 37:961-979, as amended.

Non-Profit Cancer Treatment Facility—a non-profit facility considered tax-exempt under §501(c)(3), *Internal Revenue Code*, pursuant to 26 U.S.C. §501(c)(3), for the diagnosis and treatment of cancer or cancer-related diseases, whether or not such a facility is required to be licensed by this state.

Nurse Midwife—a registered nurse certified by the Louisiana State Board of Nursing as a certified nurse midwife.

Nursing Home—a private home, institution, building, residence or other place, licensed or provisionally licensed by the Department of Health and Hospitals, pursuant to R.S. 40:2009.2, as amended.

Optometrist—a person holding a license to engage in the practice of optometry in the state of Louisiana, pursuant to R.S. 37:1041-1068, as amended.

Person—an individual, natural person.

Pharmacist—a person holding a certificate of registration issued by the Louisiana Board of Pharmacy pursuant to R.S. 37:1171-1208, as amended.

Physical Therapist—a person holding a license to engage in the practice of physical therapy in the state of Louisiana, pursuant to R.S. 37:2401-2418, as amended.

Podiatrist—a person holding a license to engage in the practice of podiatry in the state of Louisiana, pursuant to R.S. 37:611-628, as amended.

Professional Corporation—any professional corporation a health care provider is authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950, as amended.

Psychologist—a person holding a license to engage in the practice of psychology in the state of Louisiana, pursuant to R.S. 37:2351-2366, as amended.

Registered Nurse—a person holding a license to engage in the practice of nursing in the state of Louisiana, pursuant to R.S. 37:911-931, as amended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:168 (February 1992), amended LR 29:344 (March 2003).

§113. Severability

A. If any provision of these rules, or the application or enforcement thereof, is held invalid, such invalidity shall not affect other provisions or applications of these rules which can be given effect without the invalid provisions or applications, and to this end the several provisions of these rules are hereby declared severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:168 (February 1992).

Chapter 3. Organization, Functions, and Delegations of Authority

§301. Board Organization

A. Before taking office, each member of the board duly appointed by the governor shall subscribe before a notary public, and cause to be filed with the secretary of the board, an oath in substantially the following form:

> I HEREBY SOLEMNLY SWEAR AND AFFIRM that I accept the trust imposed on me as a member of the Patients' Compensation Fund Oversight Board, and will perform the duties imposed on me as such by the laws of the state of Louisiana to the best of my ability and without partiality or favoritism to any constituency, group or interests which I may individually represent or with whom I may personally be associated.

B. The board shall annually, at its first meeting following the first day of July of each year, elect from among its members as a chairman, a vice-chairman, and a secretary, each of whom shall serve in such office until their successors are duly elected. The board may elect a successor chairman or secretary at any time that the incumbent of such office resigns from such office or by death or disability becomes incapacitated from discharging the responsibilities of such office.

C. Meetings of the board shall be noticed, convened, and held not less frequently than quarterly during each calendar year and otherwise at the call of the chairman or on the written petition for a meeting signed by not less than that number of board members constituting a quorum of the board. Meetings of the board shall be held on such date and at such time and place as may be designated by the chairman, or in default of designation by the chairman, by agreement of a quorum of the board.

D. Five members of the board shall constitute a quorum for all purposes, including the call and conduct of meetings, the rulemaking functions of the board, and the exercise of all other powers and authorities conferred on the board by law. No member of the board may be represented by proxy at any meeting of the board or otherwise vote or act on or participate in the affairs of the board by proxy. Except as may be otherwise provided by law or by the policies of the board, all actions which the board is empowered by law to take shall be effected by vote of not less than a majority of the members of the board present at a meeting of the board at which a quorum is present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation' Fund Oversight Board, LR 18:169 (February 1992).

§303. Executive Director of the Patients' Compensation Fund Oversight Board

A. The position of executive director of the Louisiana Patients' Compensation Fund Oversight Board is hereby established by the board as an unclassified position. The executive director shall be employed by the board and, subject to other provisions of law respecting qualification for and maintenance of governmental employment, hold such office at the pleasure of the board. In addition to other qualifications required by law for such office, the executive director shall be at least 21 years of age, a graduate of an accredited post-secondary college or university, and have had prior professional experience in insurance underwriting and actuarial science as appropriate to the executive director's responsibilities pursuant to these rules.

B. The executive director shall be responsible, and accountable to the board for the overall administration, operation, conservation, management, and defense of the fund to the extent of the responsibilities imposed on the board by the Act. Without limitation on the scope of such responsibility, the executive director shall be specifically responsible for:

1. receiving and processing health care provider applications for enrollment with the fund;

2. determining whether applicants for enrollment satisfy the standards of financial responsibility and possess the other qualifications for enrollment specified by these rules;

3. timely collection of surcharges from, or paid by insurers on behalf of, enrolled health care providers;

4. certification of enrollment upon the presentation of claims against health care providers enrolled with the fund;

5. processing claims against enrolled health care providers and the fund in accordance with the Act and these rules;

6. collection, accumulation, and maintenance of comprehensive historical claims experience data from enrolled health care providers and insurance companies providing professional liability coverage to health care providers in the state of Louisiana, in such form and array as may be necessary or appropriate to permit the fund's actuary to develop sound and appropriate surcharge rates for the fund;

7. maintenance of accurate, current, and complete data on pending and concluded and closed claims against the fund;

8. coordination of the defense and disposition of claims against the fund;

9. payment of judgments, settlements, arbitration awards, and medical expenses;

10. retention of an actuary for the fund in accordance with §701;

11. development and submission, in conjunction with the PCF's actuary, of surcharge rate and rate change filings with the Louisiana Insurance Rating Board, based on annual actuarial studies;

12. financial accounting for the fund in accordance with generally accepted accounting principles;

13. development and submission of an annual budget and appropriation request as provided by §§1305-1307 of these rules;

14. preparation and submission of such reports on the status, administration, and operation of the fund, and on the disposition of individual claims against the fund, as required by law or as directed by the board; and

15. the discharge and performance of such other duties, responsibilities, functions, and activities as are expressly or impliedly imposed on the board by the Act or as specified by these rules.

C. All authority for the administration and operation of the fund vested in the board by the Act is hereby delegated to the executive director. In the exercise of such authority, the executive director shall be accountable to, and subject to the superseding authority of, the board.

D. Without limitation on the generality of the provision made by §307 for the payment of the expenses of administration and defense of the fund, the salary and employment benefits of the executive director and any expenses properly and lawfully incurred by the executive director in the performance of his duties under these rules shall be payable by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:169 (February 1992), amended LR 29:344 (March 2003).

§305. Fund Property

A. The board is the custodian of all tangible and intangible property, assets, rights, and interests of the fund and the repository for all of the fund's records, files, information, and data. All furniture, fixtures, equipment, goods, supplies, files, records, information, data, computers, computer systems, software, and documentations, and any other tangible or intangible property, rights, or interests of whatsoever kind or nature purchased or acquired by, transferred or donated to, or developed or produced through the use of funds of the PCF, wheresoever or howsoever located or stored, shall be and remain the property of the fund. No property, rights, or interests of the fund shall be sold, transferred, assigned, or alienated by the fund except for compensation to the fund equal to or exceeding the reasonably estimated market value of any such property, rights, or interests and pursuant to the authorization of the executive director.

B. The board shall annually conduct and record an inventory of all of the property, assets, rights, and interests of the fund and shall at all times maintain a current, accurate, and complete schedule of the property, assets, rights, and interests of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

§307. Expenses of Administration and Defense

A. All expenses incurred for, by, or on behalf of the executive director or the board in their administration, operation, and defense of the fund, pursuant to the Act and these rules, shall be borne by the fund, subject to the provision of these rules governing budgeting, accounting, and appropriation requests.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

Chapter 5. Enrollment with the Fund

§501. Scope of Chapter

A. The rules of Chapter 5 provide for and govern the qualifications, conditions, and procedures requisite to enrollment with the fund, demonstration and maintenance of

financial responsibility, and termination or cancellation of enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

§503. Basic Qualifications for Enrollment

A. To be eligible for enrollment with the fund, a person, professional corporation, professional partnership, or institution shall:

1. be a health care provider, as defined by the Act or by these rules, who or which is engaged in the provision of health care services within the state of Louisiana, and which is not organized solely or primarily for the purpose of qualifying for enrollment with the fund;

2. demonstrate and maintain, to the satisfaction of and in the manner specified by the executive director and in accordance with the standards prescribed by §§503-511 hereof, or as otherwise provided by law, financial responsibility for, and with respect to, malpractice or professional liability claims asserted against the person or institution;

3. make application for enrollment upon forms prescribed and supplied by the executive director, pursuant to §513 of these rules; and

4. pay the applicable surcharges to the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992).

§505. Financial Responsibility: Insurance

A. A health care provider shall be deemed to have demonstrated the financial responsibility requisite to enrollment with the fund by submitting certification that the health care provider is or will be insured on a specific date under a policy of insurance, insuring the health care provider against professional health care malpractice liability claims with indemnity limits of not less than $100,000, plus interest per claim, aggregate annual indemnity limits of not less than $300,000 plus interest for all claims arising or asserted within a 12-month policy period.

B. To be acceptable as evidence of financial responsibility pursuant to §505, an insurance policy:

1. must be issued:

a. by an insurance company admitted to do business in this state; or

b. by an unauthorized insurer which is on the list of approved unauthorized insurers maintained by the Commissioner of Insurance pursuant to R.S. 22:1262.1 and which has:

i. a rating by A.M. Best and Co. of "A-" or higher; or

ii. a rating by Standard and Poor's of "AA-" or higher; or

iii. a rating by Moody's of "Aa" or higher; or

c. by a risk retention group organized and operating in this state pursuant to the Federal Liability Risk Retention Act of 1986, 15 U.S.C. 3901 et seq., and which has given notice of its operation within this state to the Commissioner of Insurance and is otherwise in compliance with the Louisiana Risk Retention Group Law, R.S. 22:2071 et seq.; or

d. by the Louisiana Residual Malpractice Insurance Authority, R.S. 40:1299.46;

2. shall be of a form approved by the Commissioner of Insurance of the state of Louisiana and specifically approved by the executive director;

3. must provide for the insurer's assumption of the defense of any covered claim, without limitation on the insurer's maximum obligation respecting the cost of defense;

4. shall be nonassessable;

5. shall not be subject to a retention or deductible payable by the insured health care provider, with respect to liability, costs of defense or claim adjustment expenses, in excess of $25,000, provided that an insurance policy provision which requires reimbursement of the insurer by the insured of indemnification and/or expenses and which provides that the insurer remains directly and primarily responsible to the patient for the amount thereof shall not be considered a retention and shall, in that regard, be deemed to satisfy the financial responsibility requirements of §505; and

6. must, by provision or endorsement, obligate the insurer to give immediate notice to the executive director of cancellation, termination, or lapse of the policy, or of modification of the scope or limits of its coverage by endorsement or otherwise.

C. The certification required by §505.A shall be issued and executed by an officer or authorized agent of the applicant health care provider's insurer and shall specifically identify the policyholder, the named insureds under such policy, the policy period, the limits of coverage and any applicable deductible or uninsured retention. Such certification shall be accompanied by a complete specimen copy of the applicable policy, or identification of the specific policy form if such form has previously been filed with and approved by the executive director.

D. Upon request, the executive director shall advise applicants as to whether any specified policy form has been approved pursuant to §505, or provide a list of all policy forms so approved.

E. The insurance coverage required by this rule to demonstrate the requisite financial responsibility for qualification with the fund shall be deemed to be continuing without a lapse in coverage by the fund, provided that the health care provider meets the premium payment conditions of the underlying coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:170 (February 1992), amended LR 21:394 (April 1995), LR 23:68 (January 1997), LR 24:333 (February 1998), LR 30:1017 (May 2004).

§507. Financial Responsibility: Self-Insurance

A. A health care provider shall be deemed to have demonstrated the financial responsibility requisite to enrollment with the fund by depositing with the board $125,000, in money or represented by irrevocable letters of credit, federally insured certificates of deposit, or in bonds, securities cash values of insurance, or other securities approved by the executive director of the principal value of not less than $125,000. All money, certificates of deposit, bonds or securities deposited pursuant to §507 shall be conditioned only for, dedicated exclusively to, and held in trust for the benefit and protection of and as security for the prompt payment of all malpractice claims arising or asserted against the health care provider.

B. For purposes of §507, upon approval by the board of an application filed by the group, any group of health care providers organized to and actually practicing together or otherwise related by ownership, whether as a corporation, partnership, limited liability partnership or limited liability company, shall be deemed a single health care provider and shall not be required to post more than one deposit. Proof of such status may include a notarized copy of the articles of incorporation, partnership agreement, articles of organization, joint or consolidated entity tax returns, or other documents demonstrating the ownership relation among or between the members of the group, or other evidence which indicates that the members of the group actually practice together for the purpose of health care delivery.

1. This proof of group status shall be submitted to the board:

a. with the group's original application;

b. within 30 days of any change in the group's status, organization, or membership; and

c. within 10 calendar days of receipt of a written demand therefor from the board.

2. It shall be insufficient for qualification under this rule if a group is organized solely or primarily for the purpose of qualifying for enrollment with the fund.

C.1 The following bonds and securities shall be deemed approved by the board for purposes of the deposit required by §507:

a. 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 full faith and credit of the United States, any state or territory of the United States, or the District of Columbia;

b. government sponsored AAA rated securities which carry an implied guarantee from the United States Government;

c. bonds or evidence of indebtedness 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 issuing body, the state, or political subdivision of this state, or any other state or territory of the United States or the District of Columbia;

d. the bond of an authorized surety company engaged in business in the state of Louisiana which has an A.M. Best rating of A+ VIII or better. In addition, the company should meet the stated minimum rating criteria for two of the following rating services:

i. Standard and Poor AA;

ii. Duff and Phelps AA;

iii. Moody's Aa2;

e. an unconditional letter of credit with an automatic renewal provision where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor;

f. an escrow account in the name of Patients' Compensation Fund where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor.

2. In addition to the above, a health care provider may apply to the board for approval of any other security which, if approved by the board, shall constitute proof of financial responsibility.

3. In addition to depositing the money or original instrument evidencing the approved security with the board, a self-insured health care provider shall be required to execute a pledge agreement prescribed and supplied by the executive director and to provide evidence that written notice, stating that the approved security will be pledged to the board pursuant to the terms of the pledge agreement, has been given to the issuing body.

D. Money, accounts, certificates of deposit, or other approved insurance or securities deposited, pledged or assigned to the board pursuant to §507 shall not be assigned, transferred, sold, mortgaged, pledged, hypothecated or otherwise encumbered by the health care provider nor shall any such deposit, account, or certificate of deposit be subject to writ of attachment, sequestration, or execution except pursuant to a final judgment or court-approved settlement issued or made in connection with and arising out of a malpractice claim against the health care provider.

E. To maintain financial responsibility for continuing enrollment or qualification with the fund, a health care provider shall at all times maintain the unimpaired principal value of the deposit provided for by §507 at not less than $125,000. The value of the health care provider's deposit shall be deemed impaired when any portion is seized pursuant to judicial process.

F.1. Reserves for claims against a self-insured health care provider shall, for the purposes of §507, be established in any of the following ways:

a. the self-insured health care provider shall, within 90 days of notice of a claim and no less than every 90 days thereafter, submit a proposed reserve amount to the executive director, along with appropriate supporting documentation. Unless rejected by the executive director within 30 days of receipt, the reserve amount submitted shall be deemed approved. If a reserve amount is rejected timely, the self-insured health care provider may, within 15 days, submit a new reserve amount or appeal the rejection of the executive director. If appealed timely, the matter shall be placed on the agenda of the next meeting of the board, at which time the board may accept the proposed reserve, establish a new amount, or defer action for further information. The decision of the board shall be final;

b. the self-insured health care provider may contract with a consultant company approved by the board to set its reserves;

c. the self-insured health care provider may set its reserves with the assistance of in-house counsel and/or risk managers and/or defense attorneys when approved to do so by the board.

2. In granting approval under either §507.F.b or c, the board shall give consideration to the qualifications of the consultant company, in-house counsel, risk managers and/or defense attorneys including, but not limited to, experience in reserve setting and history of approval by national excess insurance companies. Under §507F.b and c, the self-insured health care provider shall submit quarterly loss-run reports to the fund, and the fund may make annual on-site inspections of the files and reserves.

G. A self-insured health care provider who evidences financial responsibility pursuant to §507 may, upon 45 days prior written notice to the executive director, withdraw any portion of the deposit prescribed by §507 provided that, following such withdrawal, the value of the deposit shall not be impaired.

H.1. A self-insured health care provider who has evidenced financial responsibility pursuant to §507 may withdraw the deposit prescribed by §507 upon authorization of the executive director. The security furnished as proof of financial responsibility, or a substitution which has been approved by the board, shall remain on deposit and pledged to the board during the term of the health care provider's enrollment as a self-insured health care provider with the fund and for the longer of a three-year period following termination of such enrollment or as long as any medical malpractice claim is pending, whether with the board or in a court of competent jurisdiction. After this time period, authorization may be given when the health care provider files with the executive director, not less than 30 days prior to the date such withdrawal is to be effected, a certificate, signed and verified under oath by the health care provider, certifying:

a. the date the health care provider terminated enrollment with the fund as a self-insured health care provider;

b. that there are no medical malpractice claims pending with the board or in a court of competent jurisdiction;

c. that there are no unpaid final judgments or settlements against or made by the health care provider in connection with or arising out of a malpractice claim; and

d. that there are no unasserted medical malpractice claims which are probable of assertion against the health care provider.

2. Effective as of the date on which a self-insured health care provider's deposit is withdrawn pursuant to §507, the health care provider's enrollment and qualification with the fund shall be terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:171 (February 1992), amended LR 18:737 (July 1992), LR 23:68 (January 1997), LR 29:344 (March 2003).

§509. Financial Responsibility: Self-Insurance Trusts

A. The shareholders of a professional corporation, the partners of a professional partnership, a solo practitioner, a health care provider institution, or a group of such institutions may demonstrate the financial responsibility requisite to enrollment with the fund by the establishment and maintenance of a financially and actuarially sound self-insurance trust, approved by the executive director, and making and maintaining, on behalf of such trust as an entity, a deposit of not less than $125,000 in money or represented by irrevocable letters of credit, federally-insured certificates of deposit, or in bonds or securities approved by the executive director, of the principal value of not less than $125,000.

B.1. The following bonds and securities shall be deemed approved by the board for purposes of the deposit required by §509:

a. 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 full faith and credit of the United States, any state or territory of the United States, or the District of Columbia;

b. government sponsored AAA rated securities which carry an implied guarantee from the United States Government;

c. bonds or evidence of indebtedness 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 issuing body, the state, or political subdivision of this state, or any other state or territory of the United States or the District of Columbia;

d. the bond of an authorized surety company engaged in business in the state of Louisiana which has an A.M. Best rating of A+ VIII or better. In addition, the company should meet the stated minimum rating criteria for two of the following rating services:

i. Standard and Poor AA;

ii. Duff and Phelps AA;

iii. Moody's Aa2;

e. an unconditional letter of credit with an automatic renewal provision where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor;

f. an escrow account in the name of Patients' Compensation Fund where the issuing bank carries a commercial paper rating of P-1 by Moody's and/or an A-1 by Standard and Poor.

2. In addition to the above, a health care provider may apply to the board for approval of any other security which, if approved by the board, shall constitute proof of financial responsibility.

3. In addition to depositing the money or original instrument evidencing the approved security with the board, a self-insured trust shall be required to execute a pledge agreement prescribed and supplied by the executive director and to provide evidence that written notice, stating that the approved security will be pledged to the board pursuant to the terms of the pledge agreement, has been given to the issuing body.

C. Application to the executive director for approval of a self-insurance trust as evidence of financial responsibility shall include:

1. identification of, by name, address, and category of practitioner or each shareholder of an applicant professional corporation, each partner of an applicant professional partnership or each health care institution participating in the self-insurance trust;

2. a certified copy of the self-insurance trust instrument and any related organizational or operational documents;

D. The executive director shall approve of a self-insurance trust if such trust meets the requirements of the Health Care Financing Administration's (HCFA) *Medicare Provider Reimbursement Manual*, Part 1, §2162.7, related to self-insurance trusts. Those standards shall not, however, be exclusive and the executive director may approve such other qualified self-insurance trusts as appropriate, although they do not meet those requirements.

E. Each self-insurance trust approved by the executive director as evidence of financial responsibility pursuant to §509 shall be subject to audit or examination upon reasonable prior notice to the trustees thereof, and each such trust shall, within 60 days of the conclusion of its fiscal year, file with the executive director financial statements setting forth the financial condition of the trust at the last day of the preceding year and for the year then ended, audited or reviewed by an independent certified public accountant.

F. Each self-insurance trust approved by the executive director as evidence of financial responsibility pursuant to §509 shall give written notice to the executive director within 10 days of any date that:

1. the trust instrument or other organizational or operational documents are amended; or

2. any participating member of the trust ceases to be a member or any new member begins participation with the trust.

G. For the purpose of determining whether the deposit required of an approved self-insurance trust is impaired, the unpaid final judgments, court-approved settlements, and reserves against claims against all members of a self-insurance trust shall be aggregated.

H.1. Reserves for claims against a self-insurance trust shall, for the purposes of §509, be established either of the following ways:

a. the self-insurance trust shall, within 90 days of notice of a claim and no less than every 90 days thereafter, submit a proposed reserve amount to the Office of Risk Management, along with appropriate supporting documentation. Unless rejected by the Office of Risk Management and the executive director within 30 days of receipt, the reserve amount submitted shall be deemed approved. If a reserve amount is rejected timely, the self-insured trust may, within 15 days, submit a new reserve amount or appeal the rejection to the board. If appealed timely, the matter shall be placed on the agenda of the next meeting of the board, at which time the board may accept the proposed reserve, establish a new amount, or defer action for further information. The decision of the board shall be final;

b. the self-insurance trust may contract with a consultant company approved by the board to set its reserves; or

c. the self-insurance trust may set its reserves with the assistance of in-house counsel and/or risk managers and/or defense attorneys when approved to do so by the board.

2. In granting approval under either §509.H.1.b or c, the board shall give consideration to the qualifications of the consultant company, in-house counsel, risk manager and/or defense attorneys including, but not limited to, experience in reserve setting and history of approval by national excess insurance companies. Under both §509.H.1.b and c, the self-insured trust shall submit quarterly loss-run reports to the fund, and the fund may make annual on-site inspections of the files and reserves.

I. A self-insurance trust approved by the executive director as evidence of financial responsibility shall be treated the same as insurance, and each health care provider covered by such a self-insurance trust shall be considered to have evidenced financial responsibility as provided in §505.

J. In the event that a self-insurance trust's deposit becomes impaired, the executive director shall give written notice of such impairment to the self-insurance trust, and the self-insurance trust shall, unless a shorter or longer period is provided by the board, have 120 days from receipt of such notice to make such additional deposit pursuant to §509.A as

will restore the minimum deposit value prescribed by §509. A self-insurance trust's enrollment with the fund shall terminate on and as of the last day set by these rules or, if applicable, the board, if the health care provider has not on or prior to such date restored the minimum deposit value prescribed by §509.

K. A self-insurance trust which evidences financial responsibility pursuant to §509 may, upon 45 days prior written notice to the executive director, withdraw any portion of the deposit prescribed by §509 provided that following such withdrawal, the value of the deposit shall not be impaired.

L.1. A self-insurance trust which has evidenced financial responsibility pursuant to §509 may withdraw the deposit prescribed by §509 upon authorization of the executive director. The security furnished as proof of financial responsibility, or a substitution which has been approved by the board, shall remain on deposit and pledged to the board during the term of the trust's members' enrollments as self-insured health care providers with the fund and for the longer of a three-year period following termination of such enrollment or as long as any medical malpractice claim is pending against the trust or any of its members, whether with the board or in a court of competent jurisdiction. After this time period, authorization may be given when the trust files with the executive director, not less than 30 days prior to the date such withdrawal is to be effected, a certificate, signed and verified under oath by the trustee of the trust, certifying:

a. the date that the last remaining member(s) of the trust terminated enrollment with the fund as self-insured health care provider(s);

b. that there are no medical malpractice claims against the trust or any of its members pending with the board or in a court of competent jurisdiction;

c. that there are no unpaid final judgments or settlements against or made by the trust or any of its members in connection with or arising out of a malpractice claim; and

d. that there are no unasserted medical malpractice claims which are probable of assertion against the trust or any of its members.

2. Effective as of this date on which a self-insurance trust's deposit is withdrawn pursuant to §509, the member's deposit of the trust enrollment and qualification with the fund shall be terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:172 (February 1992), amended LR 18:737 (July 1992), LR 23:69 (January 1997), LR 29:345 (March 2003).

§511. Coverage: Partnerships and Professional Corporations

A. When, and during the period that, each shareholder, partner, member, agent, officer, or employee of a corporation, partnership, limited liability partnership, or limited liability company, who is eligible for qualification as a health care provider under the Act, and who is providing health care on behalf of such corporation, partnership, or limited liability company, is enrolled with the fund as a health care provider, having paid the applicable surcharges due the fund and demonstrated and maintained financial responsibility in accordance with the standards prescribed by §§503-511 for enrollment of such individual, such corporation, partnership, limited liability partnership, or limited liability company shall, without the payment of an additional surcharge, be deemed concurrently qualified and enrolled as a health care provider with the fund when, and during the period that such corporation, partnership, limited liability partnership, or limited liability company demonstrates and maintains financial responsibility in accordance with the standards prescribed by §§503-511.

B. The corporation, partnership, limited liability partnership, or limited liability company shall furnish to the board, concurrently with its enrollment and renewal application, the name(s) of each shareholder, partner, member, agent, officer, or employee who is eligible for qualification and enrollment with the fund as a health care provider and evidence of its financial responsibility in accordance with the standards prescribed by §§503-511.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:173 (February 1992), amended LR 29:345 (March 2003), LR 30:1017 (May 2004).

§513. Enrollment Procedure

A. Application for enrollment with the fund shall be made upon forms prescribed and supplied by the executive director. The executive director shall require that each applicant supply his or its proper legal name, the applicant's principal professional address, the address of other professional offices or places of practice of the applicant, the applicant's professional license, certification, or registration number, information relating to the nature and scope of the applicant's practice sufficient to identify the class or category of the practitioner, information on malpractice claims previously concluded or then pending against the applicant, and such other information as the executive director may prescribe.

B. The application shall be accompanied by evidence of financial responsibility in the form prescribed by §§505-509 of these rules, as applicable.

C. Upon receipt of a completed application, the executive director shall advise the applicant, in writing, of the executive director's determination as to whether the

applicant is qualified for enrollment with the fund, and if qualified, of the applicable surcharge payable to the fund. The surcharge shall be paid by the applicant and collected by the fund in accordance with §§711-713 of these rules.

D. When the executive director determines that an applicant is not qualified for enrollment with the fund, he shall notify the applicant by registered or certified mail, return receipt requested, within 30 days of receipt of the completed application. The applicant may, within 15 days of receipt of the notice, appeal the determination to the board by mailing notice of said appeal by registered or certified mail, return receipt requested. If appealed timely, the matter shall be placed on the agenda of the next meeting of the board, at which time the board may hear such evidence as it deems appropriate and uphold or reverse the decision of the executive director. The decision of the board shall be final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:173 (February 1992).

§515. Certification of Enrollment

A. Upon receipt and approval of a completed application (including evidence of financial responsibility pursuant to §505, §507 or §509) and payment of the applicable surcharge by or on behalf of the applicant health care provider, the executive director shall issue and deliver to the health care provider a certificate of enrollment with the fund, identifying the health care provider and specifying the effective date and term of such enrollment and the scope of the fund's coverage for that health care provider.

B. Duplicate or additional certificates of enrollment shall be made available by the executive director to and upon the request of an enrolled health care provider or his or its attorney, or professional liability insurance underwriter when such certification is required to evidence enrollment or qualification with the fund in connection with an actual or proposed malpractice claim against the health care provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:173 (February 1992), amended LR 23:69 (January 1997), LR 29:346 (March 2003), LR 30:1018 (May 2004).

§517. Expiration, Renewal of Enrollment

A. Enrollment with the fund expires:

1. as to a health care provider evidencing financial responsibility by certification of insurance pursuant to §505 of these rules, on and as of:

a. the effective date and time of termination of the policy period of the health care provider's professional liability insurance coverage; or

b. the last day of the applicable period for which the prior annual surcharge applied in the event that the annual surcharge for renewal coverage is not paid by the health care provider to the insurer on or before 30 days following the expiration of the prior enrollment period.

2. as to a health care provider evidencing financial responsibility pursuant to §§507-509 of these rules, at 11:59 p.m., central standard time, at the conclusion of one year from the date on which enrollment became effective.

B. Enrollment with the fund must be annually renewed by each enrolled health care provider on or before termination of the enrollment period by submitting to the executive director an application for renewal, upon forms supplied by the executive director, and payment of the applicable surcharge in accordance with the rules hereof providing for the fund's billing and collection of surcharges from insured and self-insured health care providers. Each insured health care provider shall cause the insurer to submit a certificate of insurance to the executive director along with the application for renewal. Each self-insured health care provider and each health care provider covered by a self-insurance trust shall submit, along with the application for renewal, original documents which indicate that the health care provider's deposit with the board is current and/or not in default.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:174 (February 1992), amended LR 29:346 (March 2003), repromulgated LR 29:579 (April 2003).

Chapter 7. Surcharges

§701. PCF Consulting Actuary

A. In accordance with the provisions of law applicable to contracting for personal, professional, or consulting services, the executive director shall retain a qualified, competent, and independent consulting actuary to advise and consult the fund on all aspects of the fund's administration, operation, and defense which require application of the actuarial science and to perform and submit the annual actuarial study required by the Act and these rules predicate to the fund's annual surcharge rate application filings, as specified hereinafter. An individual actuary contracted by the fund, or a principal actuary assigned to the engagement and employed by a partnership, firm, or corporation contracted by the funds, shall possess formal education and at least a baccalaureate degree in the actuarial sciences, shall be a full member of the Casualty Actuarial Society, and shall have had substantial prior experience in providing services as a consulting actuary to insurance companies underwriting professional health care liability insurance.

B. The fund's contract with a consulting actuary shall provide that the consulting actuary shall be responsible for:

1. advising the executive director with respect to the necessary and proper content and form of claims experience data collected and maintained by the executive director;

2. advising the executive director with respect to the establishment, maintenance, and adjustment of reserves on individual claims against the fund and the establishment, maintenance, and adjustment of reserves for incurred but not reported claims;

3. performing actuarial analysis of claims experience data collected and maintained by the executive director with respect to the fund, commercial professional liability insurers doing business in this state, self-insured health care providers, together, as necessary or appropriate, with regional or national professional health care liability claims experience data, and development, in consideration of the fund's allocated and unallocated expenses, its organization, administration, and legal and regulatory constraints, of a surcharge rate structure, rated and classified according to the several classes or risks against which the fund provides compensation, that shall reasonably ensure that the PCF is sufficiently funded so as to be and remain financially and actuarially capable of providing the compensation for which it is organized;

4. developing, in conjunction with the executive director, surcharge rate applications and requests for surcharge rate changes in accordance with the consulting actuary's actuarial analyses, for submission to and filing with the Louisiana Insurance Rating Commission (LIRC);

5. personal presentation of surcharge rate and rate change applications on behalf of the fund at meetings of the LIRC, with the staff of the LIRC, and with such other interested or affected persons, firm, organizations, and entities as the executive director may request;

6. reviewing, and advising the executive director with respect to the funding and actuarial adequacy of self-insurance trusts and other plans submitted to the executive director by self-insured applicants for enrollment with the fund as evidence of financial responsibility; and

7. generally advising and consulting with the executive director on all actuarial questions affecting the administration, operation, and defense of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:174 (February 1992), amended LR 29:346 (March 2003).

§703. Annual Actuarial Study

A. An actuarial study of the fund and the surcharge rate structure necessary and appropriate to ensure that it is and remains financially and actuarially sound shall be performed annually by the PCF's consulting actuary on the basis of an actuarial analysis of all relevant claims experience data collected and maintained by the fund. In conjunction with the executive director, the consulting actuary shall, on behalf of the board, develop and prepare for submission to the Louisiana Insurance Rating Commission (LIRC) an application for surcharge rates or rate changes.

B. In the performance of the fund's annual actuarial study and the development of a financially sound and appropriate surcharge rate structure for the fund, the PCF's consulting actuary and the executive director shall accord the greatest weight to the claims experience of the fund and of commercial professional health care liability insurance underwriters and self-insurance funds with respect to the risk underwritten by such insurers and self-insurance funds in this state and as particularly reflected in such insurers' then most recent premium rate filings with the LIRC or such self-insurance funds' current rate structure and supporting data, provided, however, that such data shall be viewed in light of national claims experience data and provided further that the fund's consulting actuary may place reliance on national claims experience data when, in the opinion of such actuary, claims experience within the state of Louisiana as to any class of risks provides an insufficient basis for reliance thereon for purposes of actuarial analysis or in calculating indicated surcharge rates.

C. Without respect to the rate structure indicated by any annual actuarial study of the fund, no rate application which, if approved and implemented, would or could result in a reduction of the aggregate annual surcharges collected by the fund, shall be filed by the fund when the total amount of the fund is, or by effect of such rate application could become, less than 150 percent of the sum of the aggregate annual surcharges collected by the fund, reserves against individual claims, reserves for incurred but not reported claims, and allocated and unallocated expenses of the fund's administration, operation, and defense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 19:204 (February 1993), LR 24:1111 (June 1998).

§705. Risk Rating

A. Surcharge rates collected by the fund shall be based on and classified according to the classes and categories of health care liability risks underwritten by the fund with respect to each class of health care practitioners and institutions eligible for enrollment with the fund. With regard to hospitals, surcharge rates collected by the fund shall be based on the annual average number of occupied beds. Risk classifications and ratings adopted by the fund shall be based on actuarial analysis of the claims experience of health care provider groups enrolled with the fund and equivalent data and practices of commercial insurance underwriters and self-insurance funds insuring such groups. Risk rating classifications for health care providers eligible for enrollment with the fund shall be based on Louisiana claims experience data, including the PCF's own claims experience, unless the PCF's actuary affirmatively demonstrates that, as respects any class of provider, reasonably obtainable, competent, and credible Louisiana claims experience data provides an insufficient basis for such classifications under generally accepted insurance actuarial standards, in which case regional or national claims experience data and statistics relative to such classes of health care provider may be utilized.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 29:346 (March 2003).

§707. Rate Applications, Filings; Notice of Rates

A. The PCF's application for surcharge rates or rate changes, if indicated by the annual actuarial study conducted pursuant to §703, shall be filed with the LIRC by the executive director on behalf of the board.

B. Within 30 days of the date on which the LIFIC approves surcharges rates or rate changes which may be implemented by the fund, the executive director shall give written notice of such rates or rate changes, as applicable, to each commercial insurance company authorized and admitted to do business in the state as a casualty insurer and then engaged in underwriting the professional liability risks of any class of health care provider eligible for enrollment with the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 24:1112 (June 1998).

§709. Interim, Emergency Rate Filings

A. Interim or emergency applications for surcharge rates or rate changes may be filed by the fund with the LIRC at any time when the executive director, in consultation with the PCF's consulting actuary, determines that a surcharge rate change is necessary to maintain a fund surplus of not less than 50 percent of the sum of the aggregate annual surcharges collected by the fund, reserves against individual claims, reserves for incurred but not reported claims, and allocated and unallocated expenses of the fund's administration, operation, and defense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992).

§711. Payment of Surcharges: Insurers

A. Applicable surcharges for enrollment and qualification with the fund shall be collected on behalf of the fund by commercial professional health care liability insurance companies and approved self-insurance trust funds from insured health care providers electing to enroll and qualify with the fund. Such surcharges shall be collected by such insurers and funds at the same time and on the same basis as such insurers' and fund's collection of premiums or contributions from such insureds. Surcharges collected by such insurers and funds on behalf of the fund shall be due and payable and remitted to the fund by such insurers and funds within 45 days from the date on which such surcharges are collected from any insured health care provider.

B. Annual surcharges for renewal coverage due the fund by insured health care providers whose surcharges are collected by insurers and funds for enrollment and qualification with the fund shall be due and payable to the collecting insurers and funds on or before 30 days following the expiration of the prior enrollment period. Remittance of surcharges to the fund by the insurers and funds shall be made in such form and accompanied by records in such forms or on such forms as may be prescribed by the executive director so as to provide for proper accounting of remitted surcharges and the identity and class of health care providers on whose behalf such surcharges are remitted. Such insurers and funds remitting surcharges to the fund shall certify to the fund, at the time of remitting such surcharge to the fund, the date that the surcharges were collected by them from the health care providers. The payment of surcharges by an approved self-insurance trust that does not collect premiums or contributions from insureds will be governed by §713 hereof.

C. Failure of the commercial professional health care liability insurers, commercial insurance underwriters, and approved self-insurance trust funds to remit payment within 45 days of collecting such annual surcharge shall subject the commercial professional liability insurers, commercial insurance underwriters, and approved self-insurance trust funds to a penalty of 12 percent of the annual surcharge and all reasonable attorney's fees. Upon the failure of the commercial professional health care liability insurers, commercial insurance underwriters and approved self-insurance trust funds to remit as provided in §711, the board may institute legal proceedings to collect the surcharge, together with penalties, legal interest, and attorney's fees.

D. If the instrument used to pay the surcharge is returned to the fund by the payor institution and/or payment hereon is denied for any reason, the health care provider shall be notified thereof by the fund. If the surcharge is not paid in full by certified check, cashier's check, money order, or cash equivalent funds received by the fund within 10 calendar days of the provider's receipt of said notice, then the provider's coverage with the fund shall be terminated as of the end of the previous enrollment period.

E. It is the purpose of §711 that insurers and approved self-insurance trust funds remit surcharges collected from their insured providers to the fund timely. The timeliness of surcharge remittances to the fund by insurers and approved self-insurance trust funds shall not affect the effective date of fund coverage. However, the failure of insured health care providers to timely remit applicable surcharges to insurers and approved self-insurance trust funds for renewal may result in lapses of coverage with the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 20:432 (April 1994), LR 23:69 (January 1997), LR 29:346 (March 2003).

§713. Payment of Surcharges: Self-Insureds

A. Not less than 60 days prior to the termination of enrollment of a health care provider, the executive director shall cause each self-insured health care provider enrolled with the fund and each self-insured health care provider having been approved for enrollment with the fund, to receive a statement of surcharges due the fund by the health care provider for enrollment with the fund during the succeeding enrollment year.

B. Surcharges due the fund by self-insured health care providers for enrollment with the fund for an enrollment year shall be due and payable to the fund prior to the effective date of the coverage, or renewal of coverage, to which the surcharge applies. Remittance of surcharges to the fund shall be made in such form and accompanied by records in such form or on such forms as may be prescribed by the executive director so as to provide for proper accounting of remitted surcharges and the identity and class of health care provider remitting surcharges.

C. If the instrument used to pay the surcharge is returned to the fund by the payor institution and/or payment hereon is denied for any reason, the health care provider shall be notified thereof by the fund. If the surcharge is not paid in full by certified check, cashier's check, money order, or cash equivalent funds received by the fund within 10 calendar days of the provider's receipt of said notice, then the provider's coverage with the fund shall be terminated as of the end of the previous enrollment period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 20:432 (April 1994), LR 23:69 (January 1997).

§715. Amount of Surcharges; Form of Coverage; Conversions

A. A health care provider qualified for enrollment by evidence of liability insurance pursuant to §505, or by evidence of participation in an approved self-insurance trust pursuant to §509, shall pay the fund surcharge amount in the most recently approved rate filing which is applicable to his provider type, years enrolled in the fund, and which most closely corresponds to the class and form of coverage of said primary liability insurance or self-insurance trust. The form of coverage provided by the fund shall be identical to that provided by the qualifying policy of insurance or self-insurance except where the policy conflicts with applicable law or regulation.

B. A health care provider qualified for enrollment by evidence of self-insurance pursuant to §507 shall pay the fund surcharge amount in the most recently approved rate filing which is applicable to self-insured coverage and to his provider type. The form of coverage provided by the fund shall be self-insured coverage as defined in §109.A of these rules.

C.1. When a health care provider who had previously purchased claims-made coverage from the fund elects to purchase occurrence coverage from or discontinue enrollment in the fund, he shall not have coverage afforded by the fund for any claims arising from acts or omissions occurring during the fund's claims-made coverage but asserted after the termination of the claims-made coverage unless he evidences financial responsibility for those claims either by purchasing an extended reporting endorsement or posting a deposit with the board pursuant to §507 and pays, on or before 45 days following the termination of the claims-made coverage, the surcharge applicable to fund tail coverage for the corresponding claims-made period(s).

2. When a health care provider who had previously purchased claims-made coverage from the fund elects to purchase self-insured coverage from the fund, he shall not have coverage afforded for any claims arising from acts or omissions occurring during the fund's claims-made coverage but asserted after the termination of the claims-made coverage, unless he evidences financial responsibility for those claims either by purchasing an extended reporting endorsement or posting a second deposit with the board pursuant to §507 and pays, on or before 45 days following the termination of the claims-made coverage, the surcharge applicable to fund tail coverage for the corresponding claims-made period(s).

3. In special circumstances, the board may, at its discretion, waive the payment of an additional surcharge and allow tail coverage to a provider without the payment of the applicable surcharge. Each such case requires an individual written request for relief to the board, and will be decided on individual circumstances. The board's criteria for such decisions shall include, but not be limited to:

a. the reason for such request;

b. the length and basis of the provider's enrollment with the fund;

c. the potential claims liability to the fund;

d. the provider's intention to cease or continue to practice in Louisiana; and

e. the potential effects if the fund refuses to allow such relief.

D. When a health care provider who had previously purchased claims-made coverage from the fund permanently retires after 10 consecutive years of enrollment, or when an institutional provider and any successors who had previously purchased claims-made coverage from the fund permanently ceases to do business and/or practice medicine after 10 consecutive years of coverage, or when a health care provider who had previously purchased claims-made from the fund dies or becomes permanently disabled, then the surcharge to the fund for tail coverage for claims occurring during the existence of the fund claims-made coverage shall be considered to have been paid. However, continuous coverage through the fund under this rule shall only apply if the affected provider or institution maintains continuous financial responsibility either through insurance coverage or submission of the security required for self-insurance under §507, including tail coverage, for the primary $100,000 for each claim. Further, this rule shall only apply to the successor of an institutional provider to the extent that the predecessor business entity was enrolled, and only to the single business entity which had been previously enrolled. This rule shall not apply to other business entities of the successor provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 23:69 (January 1997), amended LR 29:347 (March 2003), LR 30:1018 (May 2004).

Chapter 9. Scope of Coverage

§901. Effective Date

A. A health care provider who qualifies for enrollment with the fund by demonstrating financial responsibility through professional liability insurance pursuant to §505 of these rules, shall be deemed to become and be enrolled with the fund effective as of the date on which the surcharge payable by or on behalf of such health care provider is timely collected in accordance with §711 hereof and the applicable policies and procedures of the insurer for premium payments. If such surcharge is not timely collected, the effective date of enrollment with the fund shall be the date on which such surcharge is paid to the fund is collected or accepted by the insurer.

B. A health care provider who qualifies for enrollment with the fund by demonstrating financial responsibility by self-insurance pursuant to §507 or by participation in an approved self-insurance trust pursuant to §509 of these rules, and by payment in full of the surcharges due the fund, shall be deemed to become and be enrolled with the fund effective as of the date following the date on which a then-enrolled provider's prior term of enrollment terminates, or the date on which the provider pays the surcharges due the fund, being then qualified and eligible for enrollment with the fund, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 23:70 (January 1997), LR 29:347 (March 2003).

§903. Term of Enrollment

A. The enrollment of a health care provider qualified for enrollment by evidence of liability insurance pursuant to §505 hereof shall expire on and as of the date on which the policy period of the insurance policy evidencing such financial responsibility expires.

B. The enrollment of a health care provider qualified for enrollment by evidence of self-insurance pursuant to §507 hereof shall expire one year from the date on which such health care provider's enrollment became effective.

C. The enrollment of a health care provider qualified for enrollment by evidence of participation in approved self-insurance trust pursuant to §509 of these rules shall expire on and as of the earlier of the date on which the health care provider ceases to be a participating member of such trust or one year from the date on which such health care provider's enrollment became effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992).

§905. Scope of Coverage: Insureds

A. With respect to health care providers qualified from enrollment with the fund by evidence of liability insurance pursuant to §505 hereof, the fund shall be liable for compensation for claims asserted against the health care provider only within the scope of coverage afforded by, and subject to the limitations and exclusions of, the policy of professional liability insurance evidencing the health care provider's financial responsibility, subject to the limitation of liability prescribed by the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992).

§907. Scope of Coverage: Self-Insureds

A. With respect to health care providers qualified to enroll with the fund by evidence of self-insurance pursuant to §507 hereof, or by evidence of participation in an approved self-insurance trust pursuant to §509, the fund shall be obligated to pay compensation to the extent provided by the Act only with respect to claims arising from an incident which occurred during the effective period of enrollment, regardless of whether the provider was actively enrolled on the date on which the claim was reported, so long as the provider continues to meet the financial responsibility requirements of R.S. 40:1299.42 for continued qualification.

B. The fund's obligation for compensation shall extend to the vicarious liability of an enrolled health care provider for acts or omissions of any employee or agent of the provider when acting within the course and scope of his or her employment, except any physician, physician's assistant, certified registered nurse anesthetist, or primary nurse associate (nurse practitioner) employed by the health provider when such employed person is not enrolled with the fund. However, in the case of hospitals, the fund's obligation for compensation shall extend to the vicarious liability of the hospital for the acts or omissions of any employee or agent, other than a physician, when acting within the course and scope of his or her employment. The fund's obligation for compensation does not and shall not extend to any liability or obligation of a health care provider, which the health care provider has assumed or undertaken by contract or agreement, to indemnify, defend or hold harmless any other person, firm or corporation.

AUTHORITY NOTE: Promulgated in accordance with R~S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992), amended LR 23:70 (January 1997).

§909. Scope of Coverage: Self-Insurance Trusts

A. With respect to health care providers qualified for enrollment with the fund by evidence of participation in an approved self-insurance trust pursuant to §509 hereof, the fund shall be liable for compensation for claims asserted

against the health care provider only within the scope of coverage afforded by, and subject to the limitations and exclusions of, the self-insurance trust instrument evidencing the health care provider's financial responsibility, subject to the limitation of liability prescribed by the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992).

Chapter 11. Reporting

§1101. Reporting of Claims, Reserves, Proposed Settlement

A. Within 30 days of the date on which a malpractice claim is asserted, or of the date on which a claim becomes probable of assertion, against an enrolled health care provider, the health care provider, or the health care provider's liability insurer, shall give notice of such claim to the executive director, if the executive director has not previously received notice of the claim. Such notice shall include identification of the person or persons asserting the claim, the nature of the claim, the circumstances surrounding and the date or dates of the occurrences giving rise to the claim. Such notice shall also advise of the name and address of the attorney at law, if any, retained by the health care provider or his or its insurer to represent the health care provider in defense of the claim. If an attorney has not been retained by the health care provider or insurer at the time of such notice, notice shall thereafter be given to the executive director within 10 days of the retention of an attorney to represent the health care provider.

B. Upon the assertion of a claim against an insured health care provider enrolled with the fund or against a self-insured health care provider which establishes reserves against individual claims, the health care provider or his or its insurer, as the case may be, shall promptly give notice to the executive director of the amount of indemnity, defense cost, and other loss adjustment expense reserves as have been established and allocated to the claim by the health care provider or insurer. Within 10 days of the adjustment or modification of any such reserve, a health care provider or insurer shall give notice of such adjustment or modification to the executive director.

C. Each health care provider enrolled with the fund, or the insurer of an enrolled health care provider on behalf of such health care provider, shall give not less than 10 days prior written notice to the executive director of any proposed compromise or settlement of a malpractice claim asserted against the health care provider.

D. Within 20 days of the receipt of a malpractice claim against an enrolled health care provider in the form of a lawsuit, the health care provider, or the health care provider's liability insurer, shall furnish a copy of the lawsuit to the PCF. The health care provider, or the health care provider's liability insurer, shall also furnish to the PCF within 20 days of receipt, a copy of all amending pleadings related to the lawsuit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:177 (February 1992), amended LR 29:348 (March 2003).

§1103. Claims Experience Reporting: Insurers, Institutions and Self-Insured

A. On or before March 1 of each year, each insurance company, approved risk retention group, and approved self-insurance trust fund then providing professional health care liability insurance to any health care providers enrolled with the fund, and each enrolled self-insured health care provider shall file with the fund, through the executive director, a summary of the health care liability claims experience of such health care provider or insurer fully developed for each of the most recently concluded 10 calendar years or for such fewer years as the health care provider or insurer has engaged in business in the state. Claims experience data filed by insurance companies shall include data for all health care providers insured by such insurer in the state, whether enrolled with the fund or not.

B. The reports required by this rule shall contain such information and data and shall be made and filed upon and in accordance with such forms, instructions, and array as may be specified and supplied by the executive director, all of which shall be distributed to those required to report no later than the preceding December 1. Such reports shall be signed by an officer of the insurance company or institution and shall be certified by an independent certified public accountant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1105. Noncompliance; Failure to Report

A. Noncompliance with the reporting and filing requirements prescribed by these rules shall be deemed adequate and sufficient legal grounds for the cancellation and termination of enrollment of any enrollee of the fund insured by an insurance company failing or refusing to so report.

B. Noncompliance with the reporting and filing requirements prescribed by these rules shall be deemed adequate and sufficient legal grounds for the cancellation and termination of the enrollment of any self-insured health care provider, approved risk retention group of self-insurance trust failing or refusing to report as required by these rules. The executive director shall give written notice to any self-insured health care provider which, being required to file reports under these rules, fails to do so within the time specified. The enrollment of a health care provider who does not file required reports in proper form shall be terminated 30 days following the mailing of such notice by the executive director if the health care provider has not before such date filed the required reports in proper form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1107. Confidentiality

A. All reports, notices, communications, information, records, and data made or given to the executive director or Office of Risk Management pursuant to the provisions of Chapter 11 shall be deemed privileged and confidential by and in the possession of the executive director and Office of Risk Management and their agents and contractors, and unless ordered by a court of competent jurisdiction after a contradictory hearing, shall not be disclosed to any third party pursuant to request, subpoena, or otherwise without the express written authorization and consent of the person, office, or entity making or giving, or originally possessing any such reports, notices, communications, information, records, or data. This rule shall not, however, prohibit disclosure or publication after prior consent of the board of aggregated information or data from which information or data relative to individual health care providers may not be discerned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

Chapter 13. Fund Data Collection, Maintenance; Accounting and Reporting

§1301. Fund Data Collection, Maintenance

A. All information and data collected by or reported to the fund relating to the administration, operation, or defense of the fund shall be recorded and maintained by the board. All of such information and data shall, to the extent reasonably possible, be electronically computer database stored and maintained so as to be readily and efficiently accessible for utilization in the processing of applications for enrollment, in establishment and adjustment of claim reserves and reserves for incurred but not reported claims, in the preparation and analysis of claims experience data in connection with the development of surcharge rate filings, and in the defense of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1303. Fund Accounting

A. The executive director shall be responsible for maintaining accounts and records for the fund as may be necessary and appropriate to accurately reflect the financial condition of the fund on a continuing basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1305. Annual Budget

A. The executive director shall annually, on or before December 1, project revenue and expense budgets for the fund for the succeeding fiscal year in accordance with the provisions of R.S. 39:21-38. Such budget shall reflect all revenues projected to be collected or received by or accruing to the fund during such fiscal year, together with the projected expenses of the administration, operation, and defense of the fund and satisfaction of its liabilities and obligations. Such budgets shall be submitted to the board for its approval, and as approved by the board, submitted on or before the following January 5 to the governor, the joint legislative committee on the budget, and the legislative fiscal office, in accordance with R.S. 39:33.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:178 (February 1992).

§1307. Appropriation Request

A. The executive director shall, on or before December 1 of each year, prepare an appropriation request, based on the annual budget prepared pursuant to §1305 of these rules, for approval by the board. The appropriation request on behalf of the fund, in accordance with R.S. 40:1299.44, shall be transmitted to the governor by the board on or before December 31 of each year for the succeeding fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992).

§1309. Periodic Reports

A. The executive director shall prepare or cause to be prepared, within 30 days of the conclusion of each calendar quarter, statements of the financial condition of the fund at the end of such calendar quarter and for the period then ended. Such statement may be prepared, at the election of the executive director, in accordance with the statutory accounting principles applicable to liability insurance companies authorized to do business in this state or in accordance with generally accepted accounting principles relating to accounting for governmental funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992).

§1311. Annual Report

A. On or before July 1 of each year, the executive director shall cause to be prepared an annual statement of the financial condition of the fund at December 31 of the preceding year, which statement shall be substantially in the form of the annual report required to be filed by liability

insurance companies authorized to do business in this state, and which statement shall have been audited or reviewed by the legislative auditor or by an independent certified public accountant. Such statement shall be submitted to the governor, the board, and the legislature on or before July l of each year, and shall be a public record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 19:204 (February 1993).

Chapter 14. Medical Review Panels

§1401. Procedure

A. Except as otherwise provided by the Act, all malpractice claims against health care providers shall be reviewed by a medical review panel. The composition and operation of a medical review panel shall be in accordance with R.S. 40:1299.47.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 29:348 (March 2003).

§1403. Malpractice Complaint

A. A "request for review of a malpractice claim" or "malpractice complaint" shall contain, at a minimum:

1. a request for the formation of a medical review panel;

2. name of the patient;

3. name(s) of the claimant(s);

4. name(s) of defendant health care providers;

5. date(s) of alleged malpractice;

6. brief description of alleged malpractice; and

7. brief description of alleged injuries.

B. The request for review of a malpractice claim shall be deemed filed on the date of receipt of the complaint stamped and certified by the board or on the date of mailing of the complaint if mailed to the board by certified or registered mail.

C. Within 15 days of receiving a malpractice complaint, the board shall:

1. confirm to the claimant that the malpractice complaint has been officially received and whether or not the named defendant(s) are qualified for the malpractice claim; and

2. notify all named defendant(s) that a malpractice complaint requesting the formation of a medical review panel has been filed against them and forward a copy of the malpractice complaint to each named defendant at his last and usual place of residence or his office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 29:348 (March 2003).

§1405. Attorney Chairman

A. An attorney chairman of a medical review panel is to be chosen by the parties according to R.S. 40:1299.47.C. An attorney chairman must be secured within two years from the date the request for review of the claim was filed. If, after two years, an attorney chairman has not been secured, the board shall send notice by certified mail to the claimant or the claimant's attorney stating that the claim will be dismissed after 90 days if no attorney chairman is appointed. If no attorney chairman is appointed within 90 days of the certified notice, the board shall dismiss the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 29:348 (March 2003).

Chapter 15. Defense of the Fund

§1501. Claims Defense

A. Through its executive director, the board shall be responsible for the administration and processing of claims against and legal defense of claims against the fund. The executive director shall be responsible, and accountable to the board, for coordination and management of defense of the fund against claims to the extent of the responsibilities imposed on the board by the Act. Without limitation on the scope of such responsibility, the executive director shall be specifically responsible for:

1. evaluating all malpractice claims made under the Act against enrolled health care providers to the potential liability of the fund;

2. recommending, fixing, establishing, and periodically modifying, as required, appropriate reserves against claims made against enrolled health care providers or the fund, subject to the approval of the board;

3. retaining, subject to qualifications and standards prescribed by the board, and supervising the services of attorneys at law to defend the fund against claims;

4. review and approval of fee and costs statements for services rendered by attorneys at law retained to defend the fund, ensuring that such statements accurately reflect services reasonably necessary or appropriate to the defense of the fund;

5. supervision and coordination of the defense of claims against or involving the fund by attorneys retained and representing enrolled health care providers;

6. negotiating and recommending reasonable and appropriate compromises and settlements of the fund's liability respecting any claim against the fund;

7. maintenance of current, accurate, and complete records and data on all pending and concluded claims against or involving the fund; and

8. the discharge and performance of such other duties, responsibilities, functions, and activities as are delegated by the board;

9. all authority for the defense of the fund vested in the board by the Act is hereby delegated to the executive director. In the exercise of such authority, the executive director shall be accountable to, and subject to the superseding authority of, the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 29:348 (March 2003).

§1503. Claims Accounting

A. All expenses incurred in the legal defense, disposition, payment on individual claims, judgments, or settlements shall be accounted for and allocated among such respective claims.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 29:348 (March 2003).

§1505. Claim Reserves

A. Within 10 days of receipt of notice of a claim against or potentially involving liability of the fund, the fund shall establish a reserve against such claim representing the total amount of compensation and compensation adjustment expenses which the fund is anticipated to be liable for and incur in respect of and allocable to such claim. Reserves respecting individual claims against the fund shall be established in consultation, as appropriate, with legal counsel representing the fund with respect to such claim, with legal counsel for the enrolled health care providers against whom the claim is primarily asserted, and with claims personnel managing such claim for the commercial insurers of the enrolled health care providers against whom the claim is asserted. Reserves respecting individual claims against the fund shall be adjusted from time to time as changing circumstances or evaluations may warrant, and all reserves shall be reviewed not less frequently than quarterly for necessary and appropriate adjustments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992), amended LR 29:349 (March 2003).

§1507. Settlement of Claims

A. Claims against the fund may be compromised and settled upon the recommendation of the executive director and the approval of the board. The executive director shall, however, have authority, without the necessity of prior approval by the board, to compromise and settle any individual claim against the fund for an amount not exceeding $10,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992), amended LR 29:349 (March 2003).

§1509. Privileged Communications, Records

A. All communications made and documents, records, and data developed between, by, or among the board, executive director, Office of Risk Management, PCF general counsel, contracted legal counsel, and enrolled health care providers and their insurers respecting malpractice claims asserted against enrolled health care providers or the fund shall be deemed privileged and confidential and, unless so ordered by a court of competent jurisdiction after a contradictory hearing, shall not be disclosed to any third party pursuant to request, subpoena, or otherwise, without the express written authorization and consent of the person, office, or entity making any such communication or originally possessing any such documents, records, or data. This rule shall not, however, prohibit disclosure or publication by the board of aggregated information or data from which information or data relative to individual health care providers or individual claims may not be discerned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992).

Chapter 17. Transitional Rules

§1701. Continuing Enrollment of Self-Insureds

A. A health care provider who or which is duly qualified and enrolled with the fund as a self-insured provider on and as of the effective date of these rules shall not be required to comply with the provisions of §507 of these rules respecting the amount and type of evidence of financial responsibility until:

1. 180 days from the effective date of these rules; or

2. the date on which such provider's enrollment with the fund next expires, and the provider seeks renewal of such enrollment, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992).

§1703. Continuing Enrollment of Self-Insurance Trusts

A. A health care provider who or which is duly qualified and enrolled with the fund as a self-insurance trust on and as of the effective date of these rules shall not be required to comply with the provisions of §509 hereof respecting the approval of self-insurance trusts and demonstration of financial responsibility until:

1. 180 days from the effective date of these rules; or

2. the date on which such trust's enrollment with the fund next expires, and the trust seeks renewal of such enrollment, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 18:180 (February 1992).

Chapter 19. Future Medical Care and Related Benefits

§1901. Scope of Chapter

A. The rules of Chapter 19 provide for and govern the administration and payment by the fund of future medical care and related benefits for patients deemed to be in need of future care and related benefits pursuant to a final judgment issued by a court of competent jurisdiction or agreed to in a settlement reached between a patient and the fund.

B. The rules of Chapter 19 shall be applicable to all malpractice claims, including those brought under R.S. 40:1299.39.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001).

§1903. Definitions

Future Medical Care and Related Benefits—all reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services, and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services. The fund's obligation to provide these benefits or to reimburse the claimant for those benefits is limited to the lesser of the amount billed therefor or the maximum amount allowed under the reimbursement schedule.

Reimbursement Schedule—the most recent reimbursement schedules promulgated by the Department of Labor, Office of Workers' Compensation pursuant to R.S. 23:1034.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001).

§1905. Obligation of the Fund

A. The fund shall provide and/or fund the cost of all future medical care and related benefits in the amounts provided herein, after the date of the accident and continuing as long as medical or surgical attention is reasonably necessary, that are made necessary by the health care provider's malpractice, pursuant to a final judgment issued by a court of competent jurisdiction or as agreed to in a settlement reached between a patient and the fund, unless the patient refuses to allow the future medical care and related benefits to be furnished.

B. The fund acknowledges that a court is required neither to choose the best medical treatment nor the most cost-efficient treatment for a patient. The intent of Chapter 19 is to distinguish between those devices which are reasonably necessary to a patient's treatment and those which are devices of convenience or non-essential specialty items for a patient, and to provide for the maximum allowable reimbursement for those necessary future medical care and related benefits.

C. Pursuant to the Act, the board has been, expressly and/or implicitly, vested with the responsibility and authority for the management, administration, operation, and defense of the fund and, as a prudent administrator, it must insure that all future medical care costs and related benefits are reasonable and commensurate with the usual and customary costs of such care in the patient's community. Therefore, the amount paid by the fund for future medical care and related benefits shall be the lesser of the amount billed for said care or benefit or the maximum amount allowed under the reimbursement schedule.

D. Payments for future medical care and related benefits shall be paid by the fund without regard to the $500,000 limitation imposed in R.S. 40:1299.42.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001).

§1907. Claims for Future Medical Care and Related Benefits

A. A patient, who is deemed to be in need of future medical care and related benefits pursuant to a final judgment issued by a court of competent jurisdiction or as agreed to in a settlement reached between the patient and the fund, may make a claim to the fund through the board for future medical care and related benefits made necessary by the health rare provider's malpractice.

B. If a patient's claim for future medical care and related benefits is extremely complex, is disputed or is in excess of the reimbursement schedule, then the fund may refer the matter to medical or other experts or to its counsel for review or litigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1889 (November 2001).

§1909. Attorneys; Medical Experts; Architects; Adjusters

A.1. An attorney chosen to represent the fund pursuant to §1907 shall be an independent contractor of the state of Louisiana, shall meet all applicable requirements for an outside contractor retained by the state of Louisiana, and shall be chosen by the risk director (or his successor) or his designee. The attorney shall be licensed to practice law in the state of Louisiana.

2. Once a matter involving future medical care and related benefits is referred to an attorney pursuant to §1907, then the attorney shall be responsible for the matter to the extent of the assignment (i.e., investigation and/or litigation of a particular claim, issue or request). The attorney shall issue status reports to the claims supervisor at least every 90 days until the matter is concluded.

3. The attorney chosen to represent the fund pursuant to §1907 may recommend any and all possible remedies to the fund, including litigation of any kind, and may hire or retain experts, subject to prior approval by the fund. The attorney shall utilize legal staff, including paralegals, nurse/paramedical personnel, clerks, and investigators, where necessary. With prior approval from the claims supervisor, the attorney may appoint a case manager in cases where no case manager has been appointed.

B. Pursuant to §1907, medical experts may be retained directly by the fund for evaluation, diagnosis, or with patient consent or by court order, for treatment of the patient. All medical experts retained by the fund shall be licensed or otherwise certified by the state of Louisiana. However, consulting physicians, licensed to practice in states other than Louisiana, may be retained by the fund only if they are board-certified in the applicable area of specialty.

C. Pursuant to §1907, architects with special expertise in medical facility design, contractors, and other building trade experts may be retained directly by the fund in future medical care cases involving issues of residential modifications or renovations. Architects retained by the fund shall be licensed by the state of Louisiana. Contractors retained by the fund shall be licensed or certified as general contractors by the state of Louisiana. Architects and contractors retained by the fund shall also possess experience in the design and construction of medical facility and/or barrier free residences.

D. Pursuant to §1907 and subject to fund approval, adjusters may be retained as independent contractors on the recommendation of the claims manager or of the attorney chosen to represent the fund pursuant to §1907.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1889 (November 2001).

§1911. Examinations; Notice Requirements

A. The fund shall be entitled to have a patient submit to a physical or mental examination, by a health care provider of the fund's choice, from time to time, to determine the patient's continued need of future medical rare and related benefits, subject to the following requirements.

1. Notice, in writing, shall be delivered to or served upon the patient or the patient's counsel of record, specifying the time and place where the examination will be conducted. Delivery of the notice may be by certified mail or by hand delivery. Such notice shall be given at least 10 days prior to the time stated in the notice.

2. The place at which the examination is to be conducted shall not involve an unreasonable amount of travel for the patient, considering all of the circumstances.

3. It shall not be necessary for a patient who resides outside of Louisiana to come to this state for an examination, unless so ordered by the court.

4. The examination shall be conducted by a health care provider licensed by the state of Louisiana or by the state wherein the patient resides.

B. Examinations may not be required by the fund more frequently than at six-month intervals except that, upon application to the court having jurisdiction of the claim and for reasonable cause shown therefor, examinations within a shorter interval may be ordered.

C. Within 30 days after the examination, the patient shall be compensated, by the party requesting the examination, for all necessary and reasonable expenses incidental to submitting to the examination, including the reasonable costs of travel, meals, lodging, or other direct expenses as provided elsewhere in these regulations.

D. The patient shall be entitled to have a health care provider or an attorney of his choice, or both, present at the examination. The patient shall pay such health care provider or attorney himself.

E. The patient shall be promptly furnished with a copy of the report of the examination made by the health care provider conducting the examination on behalf of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1913. Choice of Health Care Provider

A. A patient entitled to future medical care and related benefits, as determined under Chapter 19, shall be entitled to evaluation, diagnosis, and treatment by the health care providers of the patient's choice provided, however, that the health care provider rendering such evaluation, diagnosis, or treatment shall be licensed to practice medicine in Louisiana or by the state in which the patient resides. Notwithstanding the patient's right to choose his health care provider, the amount which the fund shall be required to pay or reimburse any healthcare provider shall be the lesser of the provider's billed amount or the reimbursement schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1915. Psychological /Psychiatric Treatment and Counseling

A. The fund will provide and/or fund, at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule, psychiatric/psychological testing, evaluation, diagnosis and treatment of a patient entitled to

future medical care and related benefits, as determined under Chapter 19, where these medical services are reasonable and are made necessary by the health care provider's malpractice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1917. Nursing Care; Sitter Care

A. The fund will provide and/or fund, at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule, inpatient or outpatient nursing or sitter care when such care is required to provide reasonable medical, surgical, hospitalization, physical rehabilitation, or custodial services made necessary by the health care provider's malpractice, subject to the following limitations.

1. All nursing or sitter care shall be specifically prescribed or ordered by a patient's treating health care provider.

2. All nursing or sitter care shall be rendered by a licensed and/or qualified registered nurse or licensed practical nurse or by a sitter, a member of the patient's family or household, or other person as specifically approved by the fund.

3. There shall be a presumption that the person rendering nursing or sitter care is qualified if the treating health rare provider issues a statement that that person is competent and qualified to render the nursing or sitter care required by the patient.

4. All claims for nursing or sitter care payments must include a signed, detailed statement by the person rendering nursing or sitter care, setting forth the date, time, and type of care rendered to and for the patient.

B.1. Providers of nursing or sitter care shall be funded, at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule. If the reimbursement schedule contains no applicable rate for such care, then the care shall be funded at the lesser of the billed amount or the usual and customary rate charged by similarly licensed or qualified healthcare providers in a patient's home state, city, or town. However, nursing or sitter care provided by members of the patient's family or household will be funded at a rate not to exceed $6 per hour regardless of the licensure or qualification of the provider.

2. However, notwithstanding the foregoing, future nursing or sitter care provided, after the effective date of the amended rules which provide for inflationary adjustments, by members of the patient's family or household will be funded at a rate not to exceed the equivalent of $6 per hour plus inflation at the annual consumer price index published by the United States Bureau of Labor Statistics for each year between the year of original publication of the rate (1993) and the date of service, regardless of the licensure or qualification of the provider.

C. The fund shall be entitled to periodic inspections or assessments of the physical environment in which the nursing or sitter care is being rendered. The fund may seek a judicial ruling to discontinue the payments for future medical care and related benefits if, upon inspection and recommendation of a licensed or qualified health care provider, it is determined that the physical environment in which the nursing or sitter care being rendered is inadequate or inappropriate and not in the best interest of the patient.

D. The fund may seek a judicial ruling to discontinue the payments for future medical care and related benefits if, upon a physical or mental examination of the patient, pursuant to §1911, and recommendation of a licensed or qualified health care provider, it is determined that the nursing or sitter care being rendered is inadequate or inappropriate and not in the best interest of the patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001).

§1919. Treatment Protocol

A. In cases where the future medical needs of the patient are so great that multi-disciplinary, long-term acute care is needed by the patient, and the patient and/or the patient's family, tutor, legal guardian or care givers are deemed to be incapable of determining what treatment is necessary, then the fund may obtain or develop a treatment protocol for the patient. The patient will be provided with a copy of the written treatment protocol and will be asked to consent to the treatment or course of treatment proposed by the protocol prior to implementation of the protocol.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993).

§1921. Vehicles

A. The fund will provide and/or fund the cost of standard modified vehicles or specialized modified vehicles to patients entitled to receive future medical care and related benefits under §1921, when ownership and use of such vehicles are reasonably necessary in providing reasonable medical, surgical, hospitalization, physical rehabilitation, or custodial services made necessary by the health care provider's malpractice. The vehicles described herein are standard model, modified passenger vehicles of domestic manufacture or standard model, modified vans of domestic manufacture. Alternatively, and at the fund's option, the fund mill provide and/or fund modifications to the patient's vehicle when such modifications are reasonably necessary in the provision of such services.

B. The choice of vehicle, vendor of the vehicle, modifications thereto, and inclusion or exclusion of option items on these vehicles will be at the sole discretion of the fund.

C. The fund will not provide nor fund the cost of any type of insurance for any such vehicle and will not provide nor fund the maintenance or operating costs on any vehicle modified by the fund or provided by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993).

§1923. Ancillary Cost; Mileage

A. The fund will reimburse a patient (or the patient's family or care givers) entitled to future medical care and related benefits under §1923 for actual out-of-pocket ancillary costs of medical treatment and/or care to the patient including, but not limited to, the actual costs of over-the-counter medicines and patient aids, the reasonable costs of hotel/motel accommodations and meals associated with physician appointments or treatment, when such costs are made necessary by the health care provider's malpractice.

B.1. Vehicle Not Provided by the Fund. The fund will reimburse a patient (or the patient's family or care givers) entitled to future medical care and related benefits under §1923 for actual mileage to and from physician appointments or treatment at a rate not to exceed $0.24 per mile or the current mileage rate allowance under applicable state guidelines.

2. Vehicle Provided by the Fund

a. Fund Reimbursement. Notwithstanding Paragraph B.1 or §1921.C, above, when the fund has furnished the vehicle to a patient, the fund will reimburse that patient (or that patient's family or care givers) who is entitled to future medical care and related benefits under §1923, for actual mileage to and from physician appointments or other testing or treatment, at a rate equal to 50 percent of the then applicable mileage rate.

b. Fund Credit for Non-Covered Usage. When the vehicle has been provided by the fund and the fund is required to reimburse for medically-related usage, the fund shall, however, be entitled to a credit, at the same mileage rate, for any use of the vehicle which is not eligible for reimbursement.

C. The level of expense reimbursement pursuant to §1923 shall not exceed the maximum allowable expenses under applicable state guidelines set forth in the Travel Regulations, P.P.M. 49, Louisiana Register, Vol. 16, Number 7, p. 582 or, in the case of reimbursement under Paragraph B.2 above, 50 percent of that amount.

D. Patients shall provide actual receipts or signed statements verifying the reasonable mileage for odometer readings to receive reimbursements pursuant to §1923. Expenses for hotel /motel accommodations and meals associated with physician appointments or treatment shall not be reimbursed without prior approval by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993), amended LR 27:1889 (November 2001).

§1925. Modifications/Renovations to Patient's Residence

A. The fund will provide and/or fund the cost of modifications to a patient's residence which are reasonably necessary in providing reasonable medical, physical rehabilitation, and custodial services for the patient and which are made necessary by the health care provider's malpractice. The fund will not provide nor fund the cost of devices of convenience.

B. The patient may be required to submit to a medical examination by a medical expert selected by the fund to specifically determine the patient's needs as they relate to the home. Upon completion and receipt of the medical expert's report, the patient and/or the patient's family or care givers will then be consulted by the case manager to determine specifically what modifications should be made to the home. The case manager, the fund's claims' supervisor, the claims' manager, the attorney for the fund, if one is selected, and the architect chosen by the fund will then review the report(s) of the medical expert(s) and the case manager, and then meet to determine what action will be taken as to the modifications of the home, within the specific guidelines listed below.

1. The fund will provide and/or fund the cost of modifications or renovations to the patient's existing home including, but not limited to, modifications of lavatories, including handicap accessible toilets, showers, ramps for ingress and egress, expanded doorways, and expansion of rooms to accommodate medical devices required by the patient, which are reasonably necessary for the care and rehabilitation of the patient.

2. All renovations and/or modifications will be designed and built with builders spec or similar grade materials from plans drawn and/or approved by an architect obtained by the fund.

3. When the fund has provided and/or funded modifications or renovations to the home where the patient resides, the fund shall retain no interest in that residence. Where the home is owned by the patient's parents, relatives, care givers, or guardian, the fund reserves the right to require the owners of the home to execute a promissory note, mortgage, or other instrument of security in favor of the patient in an amount equal to the increased value of the home, as determined by a qualified appraiser retained by the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1568 (December 1993).

§1927. Testimony; Communications

A. Any health care provider selected and paid by the fund who shall make or be present at an examination of the patient conducted pursuant to §1911 may be required to testify as to the conduct thereof and the findings so made.

B. Communications made by the patient during the examination conducted pursuant to §1911 by the health care provider shall not be considered privileged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1569 (December 1993).

§1929. Fees and Costs

A. The fund shall pay all reasonable fees and costs of examinations, including the costs and fees of expert witnesses in any proceeding, where termination of medical care and related benefits is sought.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1569 (December 1993).

§1931. Attorney Fees

A. Pursuant to its continuing jurisdiction, the district court, from which a final judgment has been issued in cases where future medical care and related benefits have been determined to be needed by a patient, shall award reasonable attorney fees to the patient's attorney if the court finds that the fund unreasonably failed to pay for medical care and related benefits within 30 days after submission of a claim for payment of such benefits.

B. A patient and/or the patient's attorney shall not be entitled to attorney fees in any action to enforce rights pursuant to §1931.A if the patient fails or refuses to submit to examination in accordance with a notice and if the requirements of §1911 have been satisfied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.44.D(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patients' Compensation Fund Oversight Board, LR 19:1569 (December 1993).

Title 37
INSURANCE
Part VII. Motor Vehicles

Chapter 1. Insurance

Subchapter A. Self Insurance

§101. Certificates of Self Insurance

A. Place of Application. Applications for certificates of self-insurance shall be made at the Driver Management Bureau, 109 South Foster Drive, Baton Rouge, Louisiana, or through the mail by writing to Department of Public Safety, Record Management Section, Self-Insurance Unit, Box 64886, Baton Rouge, LA 70896.

B. Applications

1. All applications for certificates of self-insurance shall be made on Form LC-75 or revisions thereof. In cases where the applicant has more than 25 vehicles registered in his name, the application shall be accompanied by the following items:

a. a list of all vehicles registered in the name of the applicant including the make, model, year, vehicle identification number, and current license plate number;

b. a financial statement of assets, liabilities, and net worth in sufficient detail to show that the applicant is possessed and will continue to be possessed of the ability to pay judgments.

2. In cases where the applicant has 25 or fewer vehicles registered in his name, the application shall be accompanied, in addition to Subparagraphs a and b above, by the following items:

a. a statement from the assessor in each parish wherein the applicant owns immovable property assessed in his name which statement shall include a description of the property, the assessed valuation thereof, and whether the property is subject to a homestead exemption;

b. a mortgage certificate on each parcel of property listed in response to §101.B.2.a;

c. an appraisal, in writing, of the fair market value of each parcel of property listed in response to §101.B.2.a, given by a person qualified to give appraisals in this state.

C. Issuance. The department shall have 30 days from the date of filing of the application either to issue or deny the application. Failure to deny within that time shall be considered the same as issuance of the certificate. Issuance shall be evidenced by a written certificate signed by the secretary, or his designated representative, and mailed to the applicant at the address given on the application.

D. Limitation on Issuance. No certificate shall be issued to any applicant whose net worth, as shown in the application, is less than the sum obtained by multiplying $10,000 by the number of vehicles registered in applicant's name and adding $5,000 thereto.

E. Renewal. Every person to whom a certificate of self-insurance has been issued shall reapply annually, as provided above, on or before July 1, except that a parcel of property once having been appraised need not be reappraised more often than every five years. Failure to reapply timely or the filing of false information regarding the applicant's financial condition shall be grounds for cancellation of the certificate under §101.F.

F. Cancellation. Upon not less than five days notice and a hearing pursuant to such notice, the Department of Public Safety may, upon reasonable grounds, cancel a certificate of self-insurance. Failure to pay a judgment within 30 days after such judgment shall have become final shall constitute a reasonable ground for the cancellation of a certificate of self-insurance.

G. Hearings. Hearings called pursuant to §101.F, shall be conducted by the secretary or his designated representative in accordance with the administrative rules of the Department of Public Safety.

H. Appeals. Any person whose application is denied or whose certificate is canceled may apply for judicial review as provided in R.S. 32:852.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:1042.

HISTORICAL NOTE: Promulgated by the Department of Public Safety, Office of Motor Vehicles, LR 4:296 (August 1978).

Subchapter B. Compulsory Motor Vehicle Liability Security

§123. Maintenance of Compulsory Motor Vehicle Liability Security

A. Applicability. Every self-propelled motor vehicle registered in this state, except those motor vehicles used primarily for exhibit or kept primarily for use in parades, exhibits, or show, shall be covered by compulsory motor vehicle liability security.

B. Compliance. The registered owner of every vehicle included in §123.A shall maintain compulsory motor vehicle liability security at all times while the vehicle is used upon the highways of Louisiana in one of the following forms:

1. an automobile liability policy, as defined by R.S. 32:900, or a binder for same, providing coverage of at least $5,000 on account of injury to or death of any one accident resulting in injury or death of more than one person and not less than $1,000 coverage for damages to the property of others;

2. a motor vehicle liability bond which means a bond conditioned that obligor shall, within 30 days after the rendition thereof, satisfy all judgments rendered against him or against any person responsible for the operation of the obligor's motor vehicle, with his express or implied consent in actions to recover damages for property damage or for bodily injuries, including death at any time resulting therefrom, and judgments rendered as aforesaid for consequential damages consisting of expenses incurred by a husband, wife, parent, or tutor for medical, nursing, hospital, or surgical services in connection with or on account of such bodily injuries or death sustained during the term of said bond by any person, and arising out of the ownership, operation, maintenance, control, or use upon the highways and roads of the state of such motor vehicle, to the amount or limit of not less than $5,000 on account of injury to or death of any person and subject to such limits as respects injury to or death of one person and of not less than $10,000 on account of any one accident resulting in injury to or death of more than one person. Bonds filed pursuant hereto must be written by a bonding company approved to do business in this state;

3. a deposit with the state treasurer of cash in the amount of $10,000 or bonds, stocks, or other evidence of indebtedness satisfactory to said treasurer of a market value of not less than $10,000 for each vehicle registered;

4. a certificate of self-insurance as provided by R.S. 32:1042 and rules and regulations of the Department of Public Safety.

C. Proof of Compliance

1. Each person who applies for registration of a self-propelled motor vehicle, or applies for a motor vehicle inspection tag, shall declare, in writing, on a form provided by the department that the motor vehicle is covered by security as required by R.S. 32:861, and that he or she intends to maintain said security at all times while said vehicle is used upon the highways of Louisiana.

a. If the stated security is a motor vehicle liability policy, then the person shall give the name of the insured, the name of the company, the policy number, and the dates of coverage on the policy.

b. If the stated security is a motor vehicle liability bond, then the person shall give the name of the surety or insurance company and the power of attorney number for the representative of surety or insurance company who signed on behalf of the company.

c. If the stated security is a certificate of the state treasurer, then the person shall declare in whose name the certificate was issued and the date of its issuance.

d. If the stated security is a certificate of self-insurance, then the person shall give the certificate number.

2. In addition to the declaration required above, the department, by written demand, may require at any time proof of compulsory motor vehicle liability security by any person in whose name a motor vehicle is registered. If after 30 days from the date of the written demand no proof of security has been furnished, the department shall revoke the registration of the vehicle and suspend the driving privileges of the registered owner until such time as security is provided and as provided in §123.G.

D. Minor Drivers. The application of any minor, 15 years of age or above, in the case of a driver's license, or 17 years of age or above in the case of a chauffeur's license, shall not be granted unless it is signed by either the father or mother of the applicant, who has custody of the applicant; otherwise, by the tutor, or other person having custody of him, and in any event, unless the persons in their aforesaid capacities declare that all vehicles owned by the family are covered by security, as required in R.S. 32:861, or that no vehicle is owned by the family.

E. Accident Reports. The driver of any vehicle involved in an accident or collision resulting in injury to or death of any person or total property damage to an apparent extent of $100 or more shall forward a written report of the accident or collision to the Department of Public Safety within 30 days following the accident or collision. This report shall be given by the completion of Department of Public Safety Form SR-10.

F. Sanctions for False Declaration. Should the commissioner determine that any person has, in his application for registration of any motor vehicle or in his application for a motor vehicle inspection tag, falsely declared that the motor vehicle was covered by the security required by R.S. 32:861 or that the security has lapsed, then the commissioner shall revoke the registration of the vehicle and suspend the driving privileges of the person for a period of not less than six months nor more than 18 months.

G. Sanctions for Noncompliance. Should the commissioner determine that a registered vehicle is not covered by security as required by R.S. 32:861 or that the registered owner has allowed the required security to lapse, he shall revoke the registration of the vehicle and suspend the driving privileges of the registered owner until such time as security is provided, but in any event for a period of not less than 30 days nor more than 12 months.

H. Hearings

1. Any person whose driver's license or registration tags has been suspended or revoked pursuant to the Compulsory Motor Vehicle Liability Security Law may request a hearing within 10 days from the date of the mailing of the notification withdrawal of driver privileges (Department of Public Safety Form C-2) by written request to the Department of Public Safety, Driver Management Bureau, Box 64886, Baton Rouge, LA 70896.

2. A notification of withdrawal of driving privileges shall be sent by United States mail and directed to the driver at the address given in his application for a driver's license, or on the notification of change of address pursuant to R.S. 32:406. When so addressed and mailed, notices shall be conclusively presumed to have been received by the addressee.

3. Every request for a hearing postmarked no later than 10 days from the date of mailing of the notification of withdrawal of driving privileges shall be considered timely.

4. Every person requesting such a hearing shall specify the grounds on which he bases his request. Failure to specify sufficient grounds will result in the denial of the request.

5. All hearings shall be conducted in accordance with the administrative rules of the Department of Public Safety.

I. Appeals. Every final order of suspension or revocation shall be subject to judicial review as provided in R.S. 32:852.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:861.

HISTORICAL NOTE: Promulgated by the Department of Public Safety, Office of Motor Vehicles, LR 4:297 (August 1978).

§129. Compulsory Insurance Hardship License

A. A $25 hardship license fee, plus the cost of the operator's license, will be collected from an applicant for a hardship license to drive a vehicle belonging to his employer and only in the regular course of his duties provided in R.S. 32:863 for a first time only suspension for any of the following:

1. false declaration in application for registration of any motor vehicle or in application for a motor vehicle inspection tag that the vehicle was covered by the required security;

2. registered owner of any motor vehicle has allowed the required security to lapse;

3. evidence produced that a vehicle is not covered by the required security;

4. operator of a vehicle has failed to comply with the provisions of R.S. 32:863.1.

B. The $25 hardship license fee, plus the cost of the operator's license, is collected to offset the administrative cost of preparation of the hardship license, as provided in R.S. 32:863(C-5). This hardship fee is collected in addition to the $25 reinstatement fee, as provided in R.S. 32:874.B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:863.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Motor Vehicles, LR 12:602 (September 1986), amended 13:667 (November 1987).

Title 37
INSURANCE
Part IX. Agricultural Commodities

Chapter 1. Self-Insurance Fund

§101. Definitions

A. As used in this Part:

Applicant—any person, firm, corporation, or other legal entity seeking the issuance of a warehouse license, cotton merchant, or grain dealer license from the commission or a renewal thereof.

Claim—a written notice and/or proof of loss which is filed with the Agricultural Commodity Commission Self-Insurance Program.

Claimant—any person or entity who, in writing, alleges a loss covered under the Agricultural Commodity Commission Self-Insurance Program.

Fee—with respect to the self-insurance fund, means the charge imposed by the Louisiana Agricultural Commodities Commission for participation in the self-insurance program, as contemplated in R.S. 3:3410.1.C.

Insurance—with respect to the self-insurance fund, means the amount of annual coverage the self-insurance program will provide to each warehouse and grain dealer licensee participating in the program.

Licensee—any person holding or required to hold a license as warehouse or grain dealer issued by the commission.

Loss—a licensee's failure to perform one or more legal obligations directly related to licensee's business, which failure results in damages to one or more producers, one or more holders of warehouse receipts, or the Commodities Credit Corporation.

Self-Insurance Fund—that special fund created in the state treasury for the Agricultural Commodity Commission's fees or assessments collected by the commission for participation in the self-insurance fund.

B. All other definitions given in R.S. 3:3402 and in the regulations are applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 13:234 (April 1987), amended by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 19:1303 (October 1993), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:625 (April 1998).

§103. The Fund

A. There is hereby created, pursuant to the authority granted in R.S. 3:3410.1, a fund to be used for the purposes described in the following Subsection hereof, and said fund shall be known as the Agricultural Commodities Commission Self-Insurance Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:234 (April 1987), amended LR 19:1303 (October 1993).

§105. Purpose

A. The self-insurance fund is established to guarantee the faithful performance of all duties and obligations of licensed grain dealers, cotton merchants, and licensed warehouses to agricultural producers and holders of state warehouse receipts for agricultural commodities and previous holders of state warehouse receipts released in trust in order to have commodity shipped (open storage), included but not limited to Commodity Credit Corporation, banks and lien holders, provided however that this fund does not apply to federal warehouses with regard to the requirements for federal warehouse license and bond.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 13:234 (April 1987), amended by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 19:1303 (October 1993), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:625 (April 1998).

§107. Fees

A. Fees for participation in said fund may be determined and announced annually by the commission, and the commission, in doing so, shall consider the self-insurance fund's experience and current market conditions affecting the financial status of licenses.

B. Each applicant for a warehouse license and/or cotton merchant and/or a grain dealer license who participates in the self-insurance fund shall be assessed an annual fee for participation in the self-insurance program. Said fee must accompany the application for a license, and is not refundable unless the license application or renewal is denied and, in that event, the fee will be refunded on a pro rata basis with the commission retaining a proportionate amount for any period during which coverage was provided to the applicant.

C. An applicant who does not pay said fee on or before April 30 of the new license year shall pay an additional sum equal to 10 percent of the annual fee.

D. The amount of the annual fee shall be $500 for a grain dealer or cotton merchant licensee. The annual fee for a warehouse licensee shall be determined first by calculating the amount of bond required of a license under R.S. 3:34010.C and D. If the required bond is $25,000, then the fee shall be $135. If the required bond is over $25,000, then the fee shall be $135 plus $4 per each additional $1,000 of coverage required.

E. Whenever the licensed warehouse capacity increases, the amount of the fee shall be amended to conform with the current licensed capacity of the facility or facilities covered by the fee.

F. For licensees entering the self-insurance fund during the license year, the fee shall be based on a pro-rata basis for each month of coverage provided.

G. The commission may require applicants who are participating in the self-insurance fund for the first time to pay two times the normal fee assessment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 13:234 (April 1987), amended by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 19:1304 (October 1993), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:625 (April 1998).

§109. Insurance Coverage

A. Insurance coverage available to the user of a licensed operation shall be limited to the amount of the bond required by R.S. 3:3410 and/or R.S. 3:3411 and shall be accepted in lieu of said bond as follows.

1. Each licensed grain dealer or cotton merchant shall be insured in the total aggregate amount of $50,000 for all claims in each licensed year.

2. Each licensed warehouse shall be insured in an amount not less than $25,000 and not more than $500,000 in the total aggregate amount in each licensed year as follows:

a. $0.20 per bushel for the first million bushels of licensed capacity;

b. $0.15 per bushel for the second million bushels of licensed capacity;

c. $0.10 per bushel for all bushels over two million.

3. For purposes of §109, one CWT shall equal 2.22 bushels, and one barrel shall equal 3.6 bushels.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 13:234 (April 1987), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:626 (April 1998).

§111. Claim Provisions

A. The monies in the Agricultural Commodities Commission Self-Insurance Fund shall be used solely for the administration and operation of this program of self-insurance.

B. Any claimant who wishes to assert a claim must provide, under oath, written and notarized proof of a loss covered under this program within 30 days of the loss.

C. Said written claim shall include the following information:

1. name and address of claimant;

2. name of the licensee(s) against whom claimant is asserting a loss;

3. nature of the relationship and transaction between claimant and licensee(s);

4. the date of the loss which shall be defined as the date on which claimant knew, or should have known, that a loss had occurred;

5. the amount of the loss and how calculated;

6. a concise explanation of the circumstances that precipitated the loss;

7. copies of those documents relied upon by claimant as proof of said loss.

D. Failure to furnish such proof of loss within the required time shall not invalidate nor reduce the claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

E. Upon receipt of a proof of loss, the commission will receive the claim to determine whether it is covered under the program. The burden of proof to establish the loss shall be upon the claimant.

F. Where any loss is or may be covered by other insurance or bond, the other insurance is primary and the commission may require the claimant to exhaust his remedies as to the other insurer before considering the payment of the claim.

G. Once a proof of loss has been filed against a licensee(s), the commission may make a complete inspection of the licensee's physical facilities and the contents thereof, as well as an audit of all books and records of the licensee and/or claimant, subject to the confidentiality requirements of R.S. 3:3421.

H. Once proof of loss has been filed against a licensee(s), any other claimants alleging a loss caused by said licensee(s) will have a period of 60 days within which to post and thereby file a written claim. The said 60-day period will begin to run upon publication by the commission of the notice of claim in the official local journal for legal notices, or the print publication with the highest circulation in the area serviced by the licensee. The purpose of said notice is to determine whether there are multiple claims, and in the

event of multiple claims which exceed the amount of insurance, then the proceeds available for losses of said licensee(s) will be prorated.

I. The commission shall provide a notice, by published advertisement, in the official local journal for legal notices or the print publication with the highest circulation in the area serviced by the licensee of the failure of a warehouse and/or grain dealer licensee, and all claims pursuant thereto must be filed within 60 days of the published advertisement.

J. The commissioner may, at his option, represent the producers and the patrons of a licensee in their claim against a licensee.

K. When claims against different licenses are filed timely and approved by the commission and the aggregate amount claimed exceeds the amount in the fund, those claims filed first will be paid before other claims until the fund is exhausted. However, the commission may, for good cause shown, permit the payment of any claim or claims over a period of years as it shall determine.

L. The fiscal year for the self-insurance fund shall be from July 1 through June 30 of each year. However, any claims received by the commission on or before August 15 of any calendar year shall be deemed as a claim on the self-insurance fund of the previous fiscal year. Claims against a licensee which are posted or received by the commission within 60 days of the advertisement of the first claim shall be considered as received on the same date as the first claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1 and R.S. 3:3405.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:234 (April 1987), amended LR 19:1304 (October 1993).

§113. Appeal Procedure

A. Any decision of the commission to deny or grant a claim for payment from the fund may be appealed to the commission by the licensee or claimant by seeking an adjudicatory hearing to have said decision reconsidered by the commission in accordance with Chapter 13 of Title 49 of the Louisiana Revised Statutes, as well as all subsequent appeals therefrom, provided said appellant files with the commission a written notice of appeal within 30 days of the mailing of the decision of the commission to the affected party.

B. Said notice of appeal shall contain an expressed statement of each and every basis upon which said appeal is sought and the hearing to consider same shall be limited accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1 and R.S. 3:3405.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:234 (April 1987).

§115. Subrogation

A. Whenever a claim is paid by the commission from the self-insurance fund, the claimant, by accepting said payment, subrogates his rights to the commission up to the full amount of payment, and the commission shall have the right to recover such payments from any responsible person or entity as it shall determine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1 and R.S. 3:3405.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:234 (April 1987).

§117. Limit of Self-Insurance Fund

A. The maximum amount necessary to sustain the self-insurance fund is $10,000,000. When the self-insurance fund has $10,000,000 available for payment of claims, no further fees or assessment will be collected until said fund is reduced by payment of claims or as otherwise provided for herein, provided that every participant in the fund shall have paid fees into the fund for a minimum of 15 years before any such suspension of fees are applicable to said participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1 and R.S. 3:3405.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:234 (April 1987).

§121. Participation in the Self-Insurance Fund

A. Participation in the agricultural commodity commission self-insurance fund shall be voluntary; however, for good cause shown, the commission may require a licensee to provide other security, in accordance with R.S. 3:3410.A and/or R.S. 3:3411.F, in lieu of or in addition to participation in the self-insurance fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1 and R.S. 3:3405.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:235 (April 1987).

§123. Prohibited Acts: Criminal Penalties

A. Any claimant who provides the commission with false information regarding an alleged loss may be denied payment of the claim on the basis alone.

B. Any warehouse, cotton merchant or grain dealer licensee who intentionally provides the commission with false information regarding a claim, or regarding any other matters pertaining to the self-insurance program, shall be subject, upon conviction, to penalties for perjury established under R.S. 14:123.

C. Any warehouse, cotton merchant, or grain dealer licensee who intentionally provides the commission with false information regarding a claim, or regarding any other matters pertaining to the self-insurance fund, shall be subject to a fine of up to $10,000, imprisonment for not more than 10 years, or both, for each occurrence proven at a hearing conducted in accordance with Chapter 13 of Title 49 of the Revised Statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 13:234 (April 1987), amended by

the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Agricultural Commodities Commission, LR 19:1305 (October 1993), amended by the Department of Agriculture and Forestry, Office of the Commissioner, LR 24:626 (April 1998).

§125. Validity of Rules

A. If any part of this regulation is declared to be invalid for any reason by any court of competent jurisdiction, said declaration shall not affect the validity of any other part not so declared.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3410.1 and R.S. 3:3405.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Office of Agro-Consumer Services, LR 13:236 (April 1987).

§127. Pending Litigation; Stay of Claims

A. Where the commission finds that litigation is pending which could determine whether payment of a claim is due or to whom payment of a claim is due, the claim in question may be stayed until the judgment in said litigation has become final and definitive. The commission shall give notice of the stay to any claimants whose claims have been stayed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3405 and 3:3410.1.

HISTORICAL NOTE: Promulgated as LAC 7:XXVII. 14759 by the Department of Agriculture and Forestry, Office of Agro-Consumer Services, Agriculture Commodities Commission, LR 17:955 (October 1991), repromulgated LR 19:1304 (October 1993).

Title 37
INSURANCE
Part XI. Rules

Chapter 1. Rule Number 3A—Advertisement of Medicare Supplement Insurance

§101. Purpose

A. The proper expansion of Medicare supplement insurance coverage is in the public interest. Appropriate advertising can broaden the distribution of insurance among those eligible for Medicare. Advertising can increase the awareness of beneficial forms of coverage and thereby encourage product competition. Advertising can also provide the insurance-buying public with the means by which it can compare the advantages of competing forms of coverage.

B. Insurance advertising has become increasingly important in the years since the *1956 NAIC Rules Governing Advertisement of Accident and Sickness Insurance* were developed. The increasing availability of coverage under group insurance plans and the advent of governmental benefit programs have complicated the decisions the insurance-buying public must make to avoid duplication of benefits and gaps in coverage. The consequent need for detailed information about insurance products is reflected in the requirements for disclosure established by the *1972 NAIC Rules, as amended, Governing Advertisements of Accident and Sickness Insurance*. This need for detailed disclosure is especially critical in helping to assure that individuals eligible for Medicare receive full and truthful advertising for Medicare supplement insurance. The NAIC has, therefore, determined that, while the *1972 NAIC Rules, as amended, Governing Advertisements of Accident and Sickness Insurance* did address Medicare supplement insurance, these new *Rules and Interpretive Guidelines* addressed solely to Medicare supplement insurance advertising are needed to replace the previous *1972 Rules and Interpretive Guidelines* with respect to Medicare supplement insurance advertising.

C. Although modern insurance advertising patterns much of its design after advertising for other goods and service, the uniqueness of insurance as a product must always be kept in mind in developing advertising. This is particularly true with respect to Medicare supplement insurance advertising. By the time an insured discovers that a particular insurance product is unsuitable for his needs, it may be too late for him to return to the marketplace to find a more satisfactory product.

D. The insurance-buying public should be afforded a means by which it can determine, in advance of purchase, the desirability of the competing insurance products proposed to be sold. This can be accomplished by advertising which accurately describes the advantages and disadvantages of the insurance product without either exaggerating the benefits or minimizing the limitations. Properly designed advertising can provide such description and disclosure without sacrificing the sales appeal which is essential to its usefulness to the insurance-buying public and the insurance business. The purpose of the new *NAIC Rules Governing Advertisements of Medicare Supplement Insurance* is to establish minimum criteria to assure proper and accurate description and disclosure.

E. The purpose of this rule is to provide prospective purchasers with clear and unambiguous statements in the advertisements of Medicare supplement insurance; to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising of Medicare supplement insurance in a manner which prevents unfair, deceptive, and misleading advertising and is conductive to accurate presentation and description to the insurance-buying public through the advertising media and material used by the insurance agents and companies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§103. Applicability

A. This rule shall apply to any advertisement of Medicare supplement insurance as that term is defined herein, unless otherwise specified in these rules, which the insurer knows, or reasonably should know, is intended for presentation, distribution, or dissemination in this state when such presentation, distribution, or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, producer, or solicitor, as these terms are defined in the *Insurance Code* of this state.

B. Every insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all of its Medicare supplement insurance advertisements. All such advertisements, regardless of by whom written, created, designed, or presented shall be the responsibility of the insurers benefiting directly or indirectly from their dissemination.

C. Advertising materials which are reproduced in quantity shall be identified by form numbers or other identifying means. Such identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications, or other materials used by the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§105. Definitions

Advertisement—

1.a. printed and published material, audiovisual material, and descriptive literature used by or on behalf of an insurer in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, and similar displays;

b. descriptive literature and sales aids of all kinds issued by an insurer, agent, producer, broker, or solicitor for presentation to members of the insurance-buying public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters, and lead generating devices of all kinds as herein defined; and

c. prepared sales talks, presentations, and material for use by agents, brokers, producers, and solicitors whether prepared by the insurer of the agent, broker, producer, or solicitor.

2. *advertisement* includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;

3. *advertisement* does not include:

a. material to be used solely for the training and education of an insurer's employees, agents, or brokers;

b. material used in-house by insurers;

c. communications within an insurer's own organization not intended for dissemination to the public;

d. individual communications of a personal nature with current policyholders other than material urging such policyholders to increase or expand coverages;

e. correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

f. court approved material ordered by a court to be disseminated to policyholders; or

g. a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided, the announcement must clearly indicate that it is preliminary to the issuance of a booklet.

Certificate—any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

Exception—any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

Institutional Advertisement—an advertisement having as its sole purpose the promotion of the reader's, viewer's, or listener's interest in the concept of Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

Insurer—shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan, and any other legal entity which is defined as an *insurer* in the *Insurance Code* of this state and is engaged in the advertisement of itself, or Medicare supplement insurance.

Invitation to Contract—an advertisement which is neither an institutional advertisement nor an invitation to inquire.

Invitation to Inquire—an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance which is limited to a brief description of coverage, and which shall contain a provision in the following or substantially similar form:

> "This policy has (exclusions) (limitations) (reductions of benefits) (terms under which the policy may be continued in force or discontinued). For costs and complete details of the coverage, call (or write) your insurance agent or the company (whichever is applicable)."

Lead-Generating Device—any communication directed to the public which, regardless of form, content, or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

Limitation—any provision which restricts coverage under the policy, other than an exception or a reduction.

Medicare—the *Health Insurance for the Aged Act*, Title XVIII of *The Social Security Amendments of 1965 as Then Constituted or Later Amended*, or Title 1, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and popularly known as the "*Health Insurance for the Aged Act*, as then constituted and any later amendments or substitutes thereof" or words of similar import.

Medicare Supplement Insurance—a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare by reason of age.

Person—any natural person, association, organization, partnership, trust, group, discretionary group, corporation, or any other entity.

Reduction—any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§107. Method of Disclosure of Required Information

A. All information required to be disclosed by this rule shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure, or presented in an ambiguous manner or fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§109. Form and Content of Advertisements

A. The format and content of a Medicare supplement insurance advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the department 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.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases whose meanings are clear only by implication or by the consumer's familiarity with insurance terminology shall not be used.

C. An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words, "...Insurance Policy," or similar words clearly identifying the fact that an insurance or health benefits product (in the case of health maintenance organizations, prepaid health plans, and other direct service organizations) is being offered.

D. No insurer, agent, broker, producer, solicitor, or other person shall solicit a resident of this state for the purchase of Medicare supplement insurance in connection with, or as the result of the use of any advertisement by such person or any other person, where the advertisement:

1. contains any misleading representation or misrepresentations, or is otherwise untrue, deceptive, or misleading with regard to the information imparted, the status, character, or representative capacity of such person or the true purpose of the advertisement; or

2. otherwise violates the provisions of these rules.

E. No insurer, agent, broker, solicitor, or other person shall solicit residents of this state for the purchase of Medicare supplement insurance through the use of a true or fictitious name which is deceptive or misleading with regard to the status, character, or proprietary of representative capacity of such person or the true purpose of the advertisement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§111. Advertisements of Benefits, Losses Covered, or Premiums Payable

A. Deceptive Words, Phrases or Illustrations Prohibited

1. No advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied does not remedy misleading statements.

2. No advertisements shall contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "this policy pays all that Medicare doesn't," or similar words and phrases, in a manner which exaggerates any benefit beyond the terms of the policy.

3. An advertisement which also is an invitation to join an association, trust, or discretionary group must solicit insurance coverage on a separate and distinct application which requires separate signature for each application. The insurance program must be presented so as not to mislead or deceive the prospective members that they are purchasing insurance as well as applying for membership, if that is the case.

4. An advertisement shall not contain descriptions of policy limitations, exceptions, or reductions worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a benefit builder or stating, "even pre-existing conditions are covered after six months." Words and phrases used in an advertisement to describe such policy limitations, exceptions, and reductions shall fairly and accurately describe the negative features of such limitations, exceptions, and reductions of the policy offered.

5. An advertisement of Medicare supplement insurance sold by direct response shall not state or imply that "because no insurance agent will call and no commissions will be paid to 'agents' that it is a low cost plan" or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in marketing by direct response.

B. Exceptions, Reductions, and Limitations

1. An advertisement which is an invitation to contract shall disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy.

2. When a policy contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

3. An advertisement shall not use the words "only," "just," "merely," "minimum," or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "this policy is subject to the following minimum exceptions and reductions."

C. Pre-Existing Conditions

1. An advertisement which is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term *pre-existing condition* without an appropriate definition or description shall not be used.

2. When a Medicare supplement insurance policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining automatic issue. If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

3. When an advertisement contains an application form to be completed by the applicant and returned by mail, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

a. Do you understand that this policy will not pay benefits during the first six months after the issue date for a disease or physical condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the policy issue date? YES

b. or substantially the following statement:

I understand that the policy applied for will not pay benefits for any loss incurred during the first six (6) months after the issue date due to a disease or physical condition for which I received medical advice or for which treatment was recommended by, or received from, a physician within six (6) months before the issue date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§113. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability, and Termination

A. An advertisement which is an invitation to contract shall disclose the provisions relating to renewability, cancellability, and termination and any modification of benefits, losses covered, or premium because of age or for other reasons, in manner which shall not minimize or render obscure the qualifying conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§115. Testimonials or Endorsements by Third Parties

A. Testimonials and endorsements used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.

B. A person shall be deemed a spokesperson if the person making the testimonial or endorsement:

1. has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise; or

2. has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer; or

3. has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or

4. is in any way directly or indirectly compensated for making a testimonial or endorsement.

C. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence thereto. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement". The requirement of this disclosure may be fulfilled by use of the phrase, "Paid Endorsement," or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure must be accomplished in the introductory portion of the advertisement and must be given prominence.

D. The disclosure requirement of this rule shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurers, consists of the payment of union "scale" wages required by union rules, and if the payment is actually for such "scale" for TV or radio performances.

E. An advertisement shall not state or imply that an insurer or a Medicare supplement insurance policy has been approved or endorsed by any individual, group of individuals, society, association, or other organizations, unless such is the facts and unless any proprietary

relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.

F. When a testimonial refers to benefits received under a Medicare supplement insurance policy, the specific claim date, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials which do not correctly reflect the present practices of the insurer or which are not applicable to the policy or benefit being advertised is not permissible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§117. Use of Statistics

A. An advertisement relating to the dollar amount of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from a policy advertised unless such is the fact, and when applicable to other policies or plans, shall specifically so state.

1. An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate, and where statistics are given which are applicable to a different policy, it must be stated clearly that the data do not relate to the policy being advertised.

2. An advertisement using statistics which describe an insurer, such as assets, corporate structure, financial standing, age, product lines, or relative position in the insurance business, may be irrelevant, and if used at all, must be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for Medicare supplement insurance which refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

B. An advertisement shall not represent or imply that claim settlements by the insurer are liberal or generous, or use words of similar import, or state or imply that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§119. Disparaging Comparisons and Statements

A. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services, or business methods and shall not disparage or unfairly minimize competing methods of marketing insurance.

1. An advertisement shall not contain statements such as "no red tape," or "here is all you do to receive benefits."

2. Advertisements which state or imply that competing insurance coverages customarily contain certain exceptions, reductions, or limitations not contained in the advertised policies are unacceptable unless such exceptions, reductions, or limitations are contained in a substantial majority of such competing coverages.

3. Advertisements which state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are unacceptable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§121. Jurisdictional Licensing and Status of Insurer

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression, directly or indirectly, that the insurer; its financial condition or status; or the payment of its claims; or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States government.

C. An advertisement shall not imply that approval, endorsement, or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising, or its financial conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§123. Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device which, with or without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

C. Advertisements, envelopes, or stationery which employ words, letters, initials, symbols, or other devices which are so similar to those used by governmental agencies or other insurers are not permitted if they may lead the public to believe:

1. that the advertised coverages are somehow provided by, or are endorsed by, such governmental agencies or such other insurers;

2. that the advertiser is the same as, is connected with, or is endorsed by such governmental agencies or such other insurers.

D. No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

E. No advertisement in the form of envelopes or stationery of any kind may use any names, service mark, slogan, symbol, or any device in such a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement is connected with a governmental agency, such as the Social Security Administration.

F. No advertisement may incorporate the word *Medicare* in the title of the plan or policy being advertised unless, wherever it appears, said word is qualified by language differentiating it from Medicare. Such an advertisement, however shall not use the phrase, "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

G. No advertisement shall be used that fails to include the disclaimer to the effect of, "Not connected with or endorsed by the U.S. Government or the federal Medicare program."

H. No advertisement may imply that the reader may lose a right or privilege or benefit under federal, state, or local law if he fails to respond to the advertisement.

I. The use of letter, initials, or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct, and complete name of the insurer is in close conjunction and in the same size type as the letter, initials, or symbols of the corporate name or trademark.

J. The use of the name of an agency or "_____ Underwriters" or "_____ Plan" in type, size, and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

K. The use of an address so as to mislead or deceive as to true identity of the insurer, its location, or licensing status is prohibited.

L. No insurer may use in the trade name of its insurance policy any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive, or mislead the prospective purchaser.

M. All advertisements used by agents, producers, brokers, or solicitors of an insurer must have prior written approval of the insurer before they may be used.

N. An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead generating device, must disclose such fact in the initial contact with the consumer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§125. Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy, and as such, enjoy special rates or underwriting privileges, unless such is the fact.

B. This regulation prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§127. Introductory, Initial or Special Offers

A.1. An advertisement of an individual policy shall not directly, or by implication, represent that a contract or combination of contracts is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

2. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, (i.e., mail, newspapers, radio, television, magazines and periodicals), by any one insurer. It is not applicable to solicitations of employees or members of a particular group or association who otherwise would be eligible under specific provisions of the *Insurance Code* for group, blanket, or franchise insurance. The phrase, "any one insurer," includes all the affiliated companies of a group of insurance companies under common management or control.

3. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

4. The phrase, "a particular insurance product," in §127.A.2 means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term *juxtaposition* means side by side or immediately above or below.

C. Special awards, such as a *safe driver award* shall not be used in connection with advertisements of Medicare supplement insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§129. Statements about an Insurer

A. An advertisement shall not contain statements which are untrue in fact, or by implications, misleading with respect to the assets, corporate structure, financial standing, age, or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§131. Enforcement Procedures

A. Advertising File

1. Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of its individual policies and typical printed, published, or prepared advertisements of its blanket, franchise, and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be available for inspection by this department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance

1. Each insurer required to file an annual statement which is now, or which hereafter becomes subject to the provisions of these rules, must file with this department, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the beat of his knowledge, information, and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied, or were made to comply, in all respects with the provisions of these rules and the insurance laws of this state, as implemented and interpreted by these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§133. Severability Provision

A. If any Section or portion of a Section of these rules, or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§135. Effective Date

A. This rule shall be effective on the sixtieth day following formal adoption.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

§137. Interpretive Guidelines for Rules Governing Advertisements of Medicare Supplement Insurance

A. Disclosure is one of the principal objectives of the rules and §137 states specifically that the rules shall assure truthful and adequate disclosure of all material and relevant information. The rules specifically prohibit some previous advertising techniques.

B. These rules apply to any *advertisement* as that term is defined in §105, unless otherwise specified in the rules. These rules apply to group, blanket and individual Medicare supplement insurance advertisements. Certain distinctions, however, are applicable to these categories. Among them is the level of conversance with insurance, a factor which is covered by §109.A.

C. The scope of the term *advertisement* extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to use of all media for communications by agents, brokers, producers, and solicitors.

D. A brief description of coverage in an invitation to inquire may consist of an explanation of Medicare benefits, minimum benefits, standards for Medicare supplement policies, the manner in which the advertised Medicare supplement insurance policy supplements the benefits of Medicare and meets or exceeds the minimum benefit requirements. An invitation to inquire shall not refer to cost or the maximum dollar amount of benefits payable. As with all Medicare supplement insurance advertisements, an invitation to inquire must not:

1. employ devices which are designed to create undue anxiety in the minds of the elderly or excite fear of dependence upon relatives or charity;

2. exaggerate the gaps in Medicare coverage;

3. exaggerate the value of the benefits available under the advertised policy;

4. otherwise violate the provisions of these rules.

E.1. The rule permits the use of either of the following alternative methods of disclosure.

a. The first alternative provides for the disclosure of exceptions, limitations, reductions, and other restrictions conspicuously and in close conjunction with the statements to which such information relates. This may be accomplished by disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits.

b. The second alternative provides for the disclosure of exceptions, limitations, reductions, and other restrictions not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure, or otherwise made to appear unimportant. The phrase, "under appropriate captions," means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Exclusions," "Conditions not Covered," and "Exceptions and Reductions." The use of captions such as, or similar to, the following are not acceptable because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only these Exclusions," or "Minimum Limitations."

2. In considering whether an advertisement complies with the disclosure requirements of this rule, the rule must be applied in conjunction with the form and content standards contained in §107.

F.1. The rule must be applied in conjunction with §101.E and §105 of the rules. The rule refers specifically to *format and content* of the advertisement and the *overall* impression created by the advertisement. This involves factors such as, but not limited to, the size, color, and prominence of type used to describe benefits. The word *format* means the arrangement of the text and the captions.

2. The rule requires distinctly different advertisements for publication in newspapers or magazines of general circulation, as compared to scholarly, technical, or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independently of all other pieces of material, conform to the disclosure requirements of this rule.

G. The rule prohibits the use of incomplete statements and words or phrases which have the tendency or capacity to mislead or deceive because of the reader's unfamiliarity with insurance terminology. Therefore, words, phrases, and illustrations used in an advertisement must be clear and unambiguous. If the advertisement uses insurance terminology, sufficient description of a word, phrase, or illustration shall be provided by definition or description in the context of the advertisement. As implied in §137.F, distinctly different levels of comprehension to the subscribers of various publications may be anticipated.

H. The rule prohibits the use of incomplete statements and words or phrases which create deception by omission or commission. The following examples are illustrations of the prohibitions created by the rule.

1. An advertisement which describes any benefits that vary by age must disclose the fact.

2. An advertisement that uses a phrase such as "no age limit" must disclose that premiums may vary by age or that benefits may vary by age, if such is the case.

3. Advertisements, applications, requests for additional information, and similar materials are unacceptable if they state or imply that the recipient has been individually selected to be offered insurance, or has had his eligibility for such insurance individually determined in advance, when in fact the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

4. Advertisements for group or franchise group plans which provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless such is the fact.

5. It is unacceptable to use terms such as "enroll" or "join" with reference to group or blanket insurance coverage when such is not the case.

6. An advertisement which states or implies immediate coverage is provided is unacceptable, unless suitable administrative procedures exist so that the policy is issued within 15 working days after the application is received by the insurer.

7. Applications, request forms for additional information, and similar related materials are unacceptable if they resemble paper currency, bonds, or stock certificates; or use any name, service mark, slogan, symbol, or any device in such a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services.

8. An advertisement which uses the word, "plan," without identifying it as a Medicare supplement insurance policy is not permissible.

9. An advertisement which implies in any manner that the prospective insured may realize a profit from obtaining Medicare supplement insurance is not permissible.

10. An advertisement which fails to disclose any waiting or elimination periods is unacceptable.

11. Examples of benefits payable under a policy shall not disclose only maximum benefits unless such maximum benefits are paid for loss from common or probable illnesses or accidents, rather than exceptional or rare illnesses or accidents or periods of confinement for such exceptional or rare accidents or illnesses.

12. When a range of benefit levels is set forth in an advertisement, it must be made clear that the insured will receive only the benefit level written or printed in the policy selected and issued.

13. Advertisements for policies whose premiums are modest because of their limited amount of benefits shall not describe premiums as "low," "low cost," "budget," or use qualifying words of similar import. This rule also prohibits the use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain.

14. An advertisement which exaggerates the effects of statutorily mandated benefits or required policy provisions or which implies that such provisions are unique to the advertised policy is unacceptable. For example: the phrase, "Money Back Guarantee," is an exaggerated description of the 30-day right to examine the policy and is not acceptable.

15. An advertisement which implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough," or is otherwise unusual is unacceptable. Also, the addition of a novel method of premium payment to an otherwise common plan of insurance does not render it *new*.

16. An advertisement may not omit the word *covered* when referring to benefits payable under its policy. Continued reference to *covered* is not necessary where this fact has been prominently disclosed in the advertisement.

17. An advertisement must state that benefits payable under the policy are based upon Medicare eligible expenses, if such is the case.

18. An advertisement which fails to disclose that the definition of *hospital* does not include a nursing home, convalescent home or extended care facility, as the case may be, is unacceptable.

19. A television, radio, mail, or newspaper advertisement, or lead generating device which is designed to produce leads either by use of a coupon, a request to write or to call the company, or a subsequent advertisement prior to contact must include information disclosing that an insurance agent may contact the applicant, if such is the fact.

20. Advertisements for policies designed to supplement Medicare shall not employ devices which are designed to create undue anxiety in the minds of the elderly. Such phrases as "here is where most people over 65 learn about the gaps in Medicare," or "Medicare is great, but ... ," or which otherwise exaggerate the gaps in Medicare coverage are unacceptable. Phrases or devices which unduly excite fear of dependence upon relatives or charity are unacceptable. Phrases or devices which imply that long sicknesses or hospital stays are common among the elderly are unacceptable.

21. An advertisement which is an invitation to contract implying that the coverage is supplemental to Medicare, if it does not explain the manner in which it is supplemental to Medicare coverage, is not acceptable.

22. An advertisement which is an invitation to contract for Medicare supplement insurance is unacceptable if the advertisement:

a. fails to disclose in clear language which of the Medicare benefits the policy is not designed to supplement, or if it otherwise implies that Medicare provides only those benefits which the policy is designed to supplement;

b. describes the in-patient hospital coverage of Medicare as *Medicare hospital*, or *Medicare Part A* when the policy does not supplement the non-hospital or the psychiatric hospital benefits of Medicare Part A;

c. fails to describe clearly the operation of the part or parts of Medicare which the policy is designed to supplement; or

d. describes those Medicare benefits not supplemented by the policy in such a way as to minimize their importance relative to the Medicare benefits which are supplemented.

23. Advertisements which indicate that a particular coverage or policy is exclusively for preferred risks or a particular segment of the population, or that particular segments of the population are acceptable risks, when such distinctions are not maintained in the issuance of policies, are not acceptable.

24. Any advertisement which contains statements such as "anyone can apply," or "anyone can join," other than that with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is unacceptable.

25. Any advertisement which uses any phrase or term such as "here is all you do to apply," "simply," or "merely" to refer to the act of applying for a policy which is not a guaranteed issue policy is unacceptable, unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

26. Advertisements which state or imply that premiums will not be changed in the future are not acceptable, unless the advertised policies so provide.

27. An advertisement which does not require the premium to accompany the application must not overemphasize that fact and must make the effective date of that coverage clear.

28. An advertisement which is an invitation to contract which falls to disclose the amount of any deductible and/or the percentage of any co-insurance factor is not acceptable.

I.1. The rule recognizes that certain words and phrases in advertising may have a tendency to mislead the public as to the extent of benefits under an advertised policy. Consequently, such terms (and those specified in the rules do not represent a comprehensive list , but only examples) must be used with caution to avoid any tendency to exaggerate benefits and must not be used unless the statement is literally true in every instance. The use of the following phrases, based on such terms, or having the same effect must be similarly restricted: "pays hospital, surgical, etc. bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," or "pays for financial needs." Other phrases may or may not be acceptable, depending upon the nature of the coverage being advertised.

2. The rule also prohibits words or phrases which exaggerate the effect of benefit payment on the insured's general well-being, such as "worry-free savings plan," "guaranteed savings," "financial peace of mind," and "you will never have to worry about hospital bills again."

3. Advertisements which are an invitation to contract for policies designed to supplement Medicare benefits are unacceptable if they fail to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period for which Medicare pays all hospital confinement expenses (currently 60 days) other than the initial deductible, if the policy so provides. The length of said period must be stated in days.

J. Explanations must not minimize nor describe restrictive provisions in a positive manner. Negative features must be accurately set forth. Any limitation on benefits precluding pre-existing conditions must also be restated under a caption concerning exclusions or limitations, notwithstanding that the pre-existing condition exclusion has been disclosed elsewhere in the advertisement. See §137.M, N, and O for additional comments on pre-existing conditions.)

K. The rule should be applied in conjunction with §117. Phrases such as "we cut cost to the bone" or "we deal direct with you so our costs are lower" shall not be used.

L.1. An advertisement which is an invitation to contract, as defined in §105, must recite the exceptions, reductions, and limitations, as required by the rule and in a manner consistent with §105.

2. If an exception, reduction, or limitation is important enough to use in a policy, it is of sufficient importance that its existence in the policy should be referred to in the advertisement, regardless of whether it may also be the subject matter of a provision of the Uniform Individual Accident and Sickness Policy Provision Law.

3. Some advertisements disclose exceptions, reductions, and limitations as required, but the advertisement is so lengthy that it obscures the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner which does not minimize, render obscure, or otherwise make them appear unimportant.

M. The rule implements the objective of §111.C.1 by requiring in negative terms a description of the effect of a pre-existing condition exclusion because such an exclusion is a restriction on coverage. The subdivision also prohibits the use of the phrase *pre-existing condition* without an appropriate definition or description of the term and prohibits stating a reduction in the statutory time limit as an affirmative benefit. The words *appropriate definition or description* mean that the term *pre-existing condition* must be defined as it is used by the company's claims department.

N. The phrase, "no health questions," or words of similar import shall not be used if the policy excludes pre-existing conditions. Use of a phrase such as "guaranteed issue" or "automatic issues" if a policy excludes pre-existing conditions for a certain period must be accompanied by a statement disclosing that fact in a manner which does not minimize, render obscure, or otherwise make it appear unimportant and is otherwise consistent with §105.

O. Some states require approval of the application even when the application is not attached to the policy when issued. The rule does not change such a requirement. The text of this guideline should be modified to reflect the rule applicable in the particular state.

P.1. Advertisements of cancelable Medicare supplement policies must state that the contract is cancelable or renewable, at the option of the company, as the case may be. With respect to noncancellable policies and guaranteed

renewable policies, the policy provisions, with respect to renewability, must be set forth and defined where appropriate.

2. The rule also requires a statement of the qualifying conditions which constitute limitations on the permanent nature of the coverage. These customarily fall into three categories:

a. age limits;

b. reservation of a right to increase premiums; and

c. the establishment of aggregate limits.

For example: "noncancellable and guaranteed renewable" does not fulfill the requirements of the rule if the policy contains a terminal age. In such a case, a proper statement would be "non-cancelable and guaranteed renewable to age _____." If a guaranteed renewable policy reserves the right to increase premiums, the statement must be expanded into language similar to "guaranteed renewable to age _____ but the company reserves the right to increase premium rates on a class basis." If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase, "subject to a maximum aggregate amount of $50,000," or similar language. A Medicare supplement insurance policy may have one or more of the three basic limitations, and an advertisement must describe each of those which the policy contains. Over 50 percent of new individual policy issues are guaranteed renewable; therefore, the fact that a policy is guaranteed renewable shall not be exaggerated.

3. An advertisement for a Medicare supplement insurance policy which provides for age step-rated premium rates based upon the policy year or the insured's attained age must disclose such rate increases and the times or ages at which such premium increases.

Q. The rule must be applied in conjunction with §115 and requires that all such statements must be genuine and not fictitious. Under the rule. the manufacturing, substantive editing, or "doctoring up" of a testimonial is clearly prohibited as being false and misleading to the insurance-buying public. However, language which would be unacceptable under these rules must be edited out of a testimonial.

R. The rule requires that both approval or endorsement of a policy by an individual, group of individuals, society, association, or other organization be factual, and that any proprietary relationship between the sponsoring or endorsing organization and the insurer be disclosed. For example: if the dividend under an association group case is payable to the association, disclosure of that fact is required. Also, if the insurer or an officer of the insurer formed or controls the association, that fact must be disclosed. This guideline also applies to §115.E.

S.1. An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate, and where statistics are given which are applicable to a different policy, it must be stated clearly that the data does not relate to the policy being advertised.

2. An advertisement which states the dollar amount of claims paid must also indicate the period over which such claims have been paid.

3. If the term "loss ratio" is used, it shall be properly explained in the context of the advertisement, and unless the state has issued a regulation otherwise defining the term, it shall be calculated on the basis of premiums earned to losses incurred and shall not be on a yearly run-off basis.

T. The rule does not require that statistics for this state be used since such statistics as hospital charges and average stays may vary from state to state. When nationwide statistics are used, such fact should be noted, unless the statistics on the particular point are substantially the same in a state to which the advertisement is directed. Statistics way only be used if they are current and credible.

U. The rule prohibits disparaging, unfair, or incomplete comparisons of policies or benefits which would have a tendency to decline or mislead the public. The rule does not preclude the use of comparisons by health maintenance organizations, prepaid health plans, and other direct service organizations which describe the difference between their prepaid health benefits coverage and indemnity insurance coverage.

V. The rule prohibits advertisements which imply that an insurer is licensed beyond the limits of those jurisdictions where it is actually licensed. An advertisement which contains testimonials from persons who reside in a state in which the insurer is not licensed or which refers to claims of persons residing in states in which the insurer is not licensed implies licensing in those states, and therefore, is in violation of this rule unless the advertisement states that the insurer is not licensed in those states.

W.1 Although the rule permits a reference to an insurer being licensed in a state where the advertisement appears, it does not allow exaggeration of the fact of such licensing nor does it permit the suggestion that competing insurers may not be so licensed because, in most states, an insurer must be licensed in the state to which it directs its advertising.

2. Terms such as "official" or words of similar import used to describe any policy or application form are not permissible because of the potential for deceiving or misleading the public. This guideline also applies to §119.A.3.

X. The rule prohibits advertising representing that a product is offered on an introductory, initial, or special offer basis or otherwise which:

1. will not be available later; or

2. is available only to certain individuals, unless such is the fact. This rule prohibits the repetitive use of such advertisements. Where an insurer uses enrollment periods as the usual method of advertising these policies, the rule prohibits describing an enrollment period as a special opportunity or offer for the applicant.

Y.1. The rule restricts the repetitive use of enrollment periods. The requirement of reasonable closing dates and waiting periods between enrollment periods was adopted to eliminate the abuses which formerly existed. This rule does not limit just the use of enrollment periods. It requires that a particular insurance product offered in an enrollment period through any advertising media, including the prepared presentations of agents, cannot be offered again in the state until (insert number) months from the close of the enrollment period. Thus, an insurer must choose whether to use enrollment periods or open enrollment for a product. (See §137.Y.1) for the definition of *a particular insurance product*.)

2. The rule does not prohibit multiple advertising during an enrollment period through any and all media published or transmitted within this state as long as the enrollment periods for all such advertisements have the same expiration date.

3. The rule does not prohibit the solicitation of members of a group or association for the same product even though there has not been a lapse of (insert months) since the close of a preceding enrollment period which was open to the general public for the same product.

4. The rule does not require separation by (insert number) months of enrollment periods for the same insurance product in this state if the advertising material is directed by an admitted insurer to persons by direct mail on the basis that a common relationship exists with an entity. Examples of such would be a bank and its depositors, a department store to its charge account customers, or an oil company to its credit card holders, and more than one of such organizations is sponsoring such insurance product at different times if providing such insurance under such a method is not otherwise prohibited by law. However, the (insert number) month rule does apply to one specific sponsor to the same persons in this state on the basis of their status as customers of that one specific entity only.

Z. The rule defines the meaning of *a particular insurance product* in §137.Y.1 and prohibits advertising of products having minor variations such as different periods or different amounts of daily hospital indemnity benefits in a succession of enrollment periods.

AA. The rule is closely related to the requirements of §115 concerning the use of statistics. The rule prohibits insurers which have been organized for only a brief period of time advertising that they are "old" and also prohibits emphasizing the size and magnitude of the insurer. Also, the occupations of the persons comprising the insurer's board of directors or the public's familiarity with their names or reputations is irrelevant and must not be emphasized. The preponderance of a particular occupation or profession among the board of directors of an insurer does not justify the advertisement of a plan of insurance offered to the general public as insurance designed or recommended by members of that occupation or profession. For example, it is unacceptable for an insurance company to advertise a policy offered to the general public as "the physicians' policy" or "the doctors' plan" simply because there is a preponderance of physicians or doctors on the board of directors of the insurer. The rule prohibits the use of recommendation of a commercial rating system unless the purpose, meaning, and limitations of the recommendation are clearly indicated.

BB. The text of Subsection A is identical to the text of the first paragraph of the Enforcement Section of previous drafts of the rules, except the last sentence of the Subsection has been revised to require that the advertising file be maintained either for a period of four years (rather than three as previously) or until the next regular examination of the insurer, whichever is the longer period of time.

CC. The rule is attached as an example of the text of a rule which may be used, at the option of the commissioner, in a state which reviews advertisements prior to use. The NAIC takes no position here on the question of whether direct response advertising material should be subject to prior review by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:224.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:67 (January 1991).

Chapter 3. Rule Number 4—Interlocal Risk Management Agency

§301. Purpose

A. The purpose of this rule is to adopt provisions and uniform guidelines for their interpretation as authorized specifically by Act 462 of the 1979 Session of the Legislature. This rule is designed to facilitate and implement the provisions of that Act. It is intended to supplement, not alter in any manner, the provisions of the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§303. Applicability

A. These provisions shall be applicable to any and all entities which may be defined an *interlocal risk management agency* by Act 462 of the 1979 Session of the Louisiana Legislature.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§305. Definitions

Certified Audit—an audit upon which the auditor expresses his professional opinion that the accompanying statements present fairly the financial position of the self-insurance fund in conformity with generally accepted accounting principles consistently applied, and accordingly, include such test of the accounting records and such other auditing procedures as considered necessary by such auditor.

Contingent Liability—the amount that the interlocal risk management agency may be obligated to pay in excess of a given year's normal premium collected or on hand.

Department—the Insurance Department of the State of Louisiana.

Experience Modification—the applicable experience debit or credit promulgated in accordance with those experience rating plans filed by and approved for the National Council on Compensation Insurance or the Insurance Services Office.

Fund—the interlocal risk management agency self-insurers fund.

Gross Premium—the premium determined by multiplying the payroll or other unit of exposure (segregated into the proper workmen's compensation job classification or general liability classification) times the appropriate manual rates.

Loss Fund—the retention of risk sharing for an interlocal risk management agency under the terms of an aggregate excess contract or contracts.

Manual Rate—for workmen's compensation purposes that rate filed by and approved for use in the state by the National Council on Compensation Insurance. For public liability exposure, the term means that rate filed by and approved for use by the Insurance Services Office.

Net Safety Factor—any amount needed in a given fund year, in addition to current loss' reserves to fund future loss development.

Normal Premium—the standard premium less any discount allowed.

Service Agent—a business which contracts with an interlocal risk management agency for the purpose of providing all services necessary to place and maintain a group self-insurance program.

Standard Premium—gross premium plus or minus applicable experience modification.

Statutory Workmen's Compensation Benefit—those prescribed by Title 23, Louisiana Revised Statutes of 1950, as amended.

Surplus—all other assets a fund may have on hand in excess of all loss reserves, actual and contingent liabilities, and net safety factors in all fund years.

Trustee Fund—any monies and investment under the control of the board of trustees of a self-insurance fund which are not part of the loss fund or which are not required to pay claims.

Trustees—the executive boards of the Louisiana Municipal Association or of the Police Jury Association of Louisiana, as the case may be, where those bodies have been designated in an intergovernmental agreement to administer an interlocal risk management agency or such members of such executive boards as do not decline to serve as trustees. In all other cases, *trustee* means a group of members elected by the interlocal risk management agency, for stated terms of office, to administer a group self-insurance fund and whose duties shall include responsibilities for approving applications for new members of such fund. A trustee shall not be an owner, officer, or employee of the service agent.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§307. Requirements Necessary to Obtain a Certificate of Authority as an Interlocal Risk Management Agency

A. Evidence must be submitted to the Insurance Department that two or more local government subdivisions have made an executed agreement among themselves to form and become members of an interlocal risk management agency.

B. Copies of the bylaws and other agreements must be submitted to the Insurance Department.

C. A copy of the ordinance or other enabling Act that is adopted by the political subdivisions authorizing execution of an agreement to form an interlocal risk management agency must be submitted to the Department of Insurance.

D. Each interlocal risk management agency must identify its agent for service of process to the Department of Insurance.

E. Each fund must have an annual gross premium calculated in accordance with the applicable manual premium rate or rates, plus or minus applicable experience credits or debits, of not less than $200,000.

F. An interlocal risk management agency must, at all times, maintain a contract or contracts of aggregate excess insurance of at least $5,000,000 as respects public liability claims if a fund is formed to self-insure public liability claims.

G. An interlocal risk management agency must, at all times, maintain a contract or contracts of specific excess insurance as respects workmen's compensation claims. Those contracts must provide for statutory workmen's compensation benefits which shall include provisions for unlimited medical and rehabilitation expenses, except that interlocal risk management agencies that are in existence prior to September 1, 1980 shall be deemed to be in compliance with this rule provided a contract or contracts of specific excess insurance has been submitted with a limit of liability in the amount of at least $1,000,000. On the first renewal date following September 1, 1980, the exception shall not be applicable.

H. Each interlocal risk management agency must provide statutory workmen's compensation benefits. A contract or contracts of excess insurance as provided in §307.G shall be provided to secure payment of statutory workmen's compensation benefits.

I. A copy of each contract of excess and aggregate insurance must be filed with the Department of Insurance.

J. Each risk contract must contain a provision that the Department of Insurance will be notified not less than 30 days in advance in the event of cancellation of the contract by action of either the interlocal risk management agency or the insurance company that issued the contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§309. Filing of Reports

A. A certified audited financial statement must be submitted annually. That statement must contain a review of the interlocal risk management agency operations and general conditions by a certified independent casualty actuary. During the first two years of the existence of the interlocal risk management agency, the Commissioner of Insurance, or his chief examiner, may require periodic interim financial reports. Those reports may be required on a basis no more frequent than quarterly.

B. That statement of financial condition must include a report of the outstanding workmen's compensation liabilities of the interlocal risk management agency and include details of the amount and source of all monies recoverable from any third party.

C. Summary loss data shall be filed with the Department of Insurance on each fund member within 60 days after the evaluation date of the losses being reported in a manner acceptable to the Department of Insurance.

D. Classified, audited, and properly limited payrolls and premium development on each fund member shall be submitted to the Insurance Department on acceptable forms within 60 days after the evaluation date of the summary loss information required in §309.C.

E. All of the information required in §309.D shall be submitted using classification, payroll limitations, experience modification, and rate procedure of the National Council on Compensation Insurance, or in the case of public liability, those of Insurance Services Office, as filed and approved for use in this state.

F. Failure or refusal of the interlocal risk management agency to file these reports in accordance with this rule shall be considered good cause to suspend or refuse renewal of the Certificate of Authority issued by the Commissioner of Insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§311. Solvency or Risk Management Agencies; Trustee Responsibilities

A. In order to insure the financial stability of the operations of each interlocal risk management agency, the board of trustees of each fund shall be responsible for all operations of the fund. The board of trustees of each agency shall take all necessary precautions to safeguard the assets of the fund or funds of such agency including:

1. the designation of a fiscal agent or administrator, if not otherwise provided for by Act 462 of the 1979 Regular Session of the Louisiana Legislature to administer the financial affairs of the fund, which as obligee, shall furnish a fidelity bond, or acceptable substitute, to protect the fund against misappropriation or misuse of any monies or securities. The amount of the bond, or substitution therefor, shall be determined by the interlocal risk management agency subject to approval by the insurance department. Such fiscal agent or administrator shall not be an owner, officer, or employee of the service agent;

2. retain control of all monies collected or disbursed from the fund or funds and shall segregate all monies into a claims fund and trustee fund. The amount allocated to the claims fund will be sufficient to cover payment of the entire aggregate loss fund, as defined in the aggregate excess insurance policy. Only disbursements that are credited toward the loss fund, as defined in the aggregate excess policy, will be made from the claims fund. All administration costs and other disbursements will be made from the trustee fund. The administrator of the fund shall establish a revolving fund for use by the authorized service agent, which will be replenished from time to time from the claims fund. The service agent and its employees shall be covered by a fidelity bond, with the interlocal risk management agency named as obligee in an amount sufficient to protect all monies placed in the revolving fund. Such bond and its amount shall be subject to approval by the insurance department;

3. audit of the accounts and records are provided for in Act 462 of the 1979 Regular Session of the Louisiana Legislature;

4. the board of trustees or its fiscal agent or administrator shall not utilize any of the monies collected as premiums for any purpose unrelated to workmen's compensation or public liability purposes. Further, it shall not borrow any monies from the fund, or in the name of the fund, without advising the Department of Insurance of the nature and purpose of the loan and obtaining approval. The board of trustees may, at its discretion, invest any surplus monies not needed for current obligations, but such investments shall be limited to bonds of the state of Louisiana or its political subdivisions, United States government bonds or securities, United States treasury notes, investment share accounts in any savings and loan association whose deposits are insured by a federal agency, and certificates of deposit issued by a duly chartered commercial bank, prime commercial paper and repurchase agreements, and pre-approved first mortgage loans on commercial real estate owned by the fund administrator, located within the state of Louisiana, and occupied by the fund or its trustees, administrator, or third party administrator. Deposits in savings and loan associations and commercial banks shall be limited to institutions in this state, except in those instances where higher interest rates

paid on deposits by such institutions in other states will provide better investment income and such deposits shall not exceed the federally insured amount in any one account, except that the federally insured amount on any one account may be exceeded if the amount involved in such an account does not exceed the greater of either of the two following factors:

a. five percent of the combination of surplus and undivided profits and reserves, as currently reported for each bank in this state in the banking division annual report of the Financial Institution Office of the Department of Commerce (banking control) or financial reports filed with the Office of the Comptroller of the Currency, the Federal Deposit Insurance Corporation, and the Federal Reserve Bank of Atlanta;

b. $500,000 per institution.

B. The board of trustees may delegate authority for specific functions to the administrator of the self-insurers' fund. The functions which may be delegated include, but are not limited to, such matters as contracting with a service agent, determining the premium charged to and refunds payable to members, investing surplus monies subject to the restrictions set forth in §311.A.4, and approving applications for membership. All delegated authority shall be specifically defined in the written minutes of the trustees' meetings and shall be subject to final approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§313. Interlocal Risk Management Self-Insurance Funds; Advance Premium Discounts; Surplus Distribution; Deficit

A. The trustees of any interlocal risk management agency shall not allow advance premium discounts to any member in excess of that allowed by the excess insurance underwriter, subject however, to a maximum of 15 percent of their standard premium.

B. Any surplus monies for a fund year in excess of the amount necessary to fulfill all obligations under the Workmen's Compensation Act for that fund year, including a provision for claims incurred but not reported and related expenses, may be declared to be refundable by the trustees at any time, and the amount of such declaration shall be a fixed liability of the fund at the time of the declaration. The date of payment shall be as agreed by the trustees, except that surplus monies not needed to satisfy the loss fund requirements (i.e., trustees' funds), as established by the aggregate excess contract, may be refunded immediately after the end of the fund year, with the approval of the Commissioner of Insurance. The intent of this rule is to ensure that sufficient monies are retained in the funds to assure that the total assets are $200,000 greater than total liabilities for each fund year.

C. In the event of a deficit in any fund year, the deficit shall be made up immediately from any of the following:

1. unencumbered surplus from a fund year other than the current fund year;

2. trustees' funds;

3. by assessment of the membership of the deficit fund year, if ordered;

4. by such alternative method as the Commissioner of Insurance may approve;

5. by reduction or elimination of the advance premium discount provided to members.

D. The Commissioner of Insurance shall be notified before any transfer of unencumbered surplus funds and of any method utilized to eliminate a deficit.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§315. Aggregate Excess Insurance, Interlocal Risk Management Agency; Self-Insurance

A. No contract or policy of aggregate excess insurance shall be recognized in considering the ability of an applicant to indemnify the financial obligations of its members under the Workmen's Compensation Act, unless such contract or policy complies with all of the following:

1. is issued by a casualty insurance company authorized to transact such business in this state, or a licensed resident surplus lines broker;

2. is not cancellable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Commissioner of Insurance not less than 30 days before termination by the party desiring to cancel or not renew the policy;

3. any contract or policy containing any type of commutation clause shall provide that any commutation effected thereunder shall not relieve the underwriter or underwriters of further liability in respect to claims and expenses unknown at the time of such commutation and which are subsequently reopened by or through a competent authority. If the underwriter proposes to settle their liability for future payments payable as compensation for accidents occurring during the term of the policy by the payment of a lump sum to the interlocal risk management agency, to be fixed as provided in the commutation clause of the policy, then not less than 30 days prior notice of such commutation shall be given to the Insurance Department by the underwriter(s) or its (their) agent by registered or certified mail. If any commutation is effected, then the Commissioner of Insurance shall have the right to direct that such sum be placed in trust for the benefit of the loss fund;

4. all of the following shall be applied toward the reaching of the retention level in the aggregate excess contract:

a. payments made by the employer;

b. payments due and owing to claimants of the employers;

c. payments made on behalf of the employers by any surety bond under a bond required by the Commissioner of Insurance;

d. payments made by the Interlocal Risk Management Agency security fund;

5. copies of the complete policy of aggregate excess insurance shall be filed with the Commissioner of Insurance, together with a certification that such policy fully complies with this rule and applicable statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§317. Servicing Interlocal Risk Management Agencies; Application; Requirements; Noncompliance

A. Any individual, co-partnership, or corporation desiring to engage in the business of providing one or more services for an approved workmen's compensation program for an interlocal risk management agency shall apply to, and shall satisfy the Commissioner of Insurance that it has adequate facilities and competent staff within the state of Louisiana to service the self-insurance program in such a manner as to fulfill the employers' obligations under the Workmen's Compensation Act and any rules and regulations applicable thereto. Service may include, but is not limited to, claims adjusting, industrial safety engineering, underwriting, and the capacity to provide required reporting.

B. Application for approval to act as a servicing agent for an interlocal risk management agency shall be made on the required form. The application shall contain answers to all questions propounded and shall be sworn to and approved before the service agent enters into a contract with an interlocal risk management agency. Applications for approval to act as a service agent shall be granted for a period of one year and shall be subject to renewal annually.

C. If the service agent seeks approval to service claims, then proof shall be required that it has within its organization, or has contracted on a full-time basis with, at least one person who has the knowledge and experience necessary to handle claims involving the Workmen's Compensation Act and public liability. A résumé covering that person or person's background shall be attached to the application of the service agent.

D. If the service agent seeks approval to provide underwriting services, then proof shall be required that it has within its organization, or has contracted on a full-time basis with at least one person who has the knowledge and experience necessary to provide underwriting services for workmen's compensation excess insurance and public liability coverage. A résumé covering that person or person's background shall be attached to the application of the service agent.

E. If the service agent seeks approval to furnish safety engineering services, then proof shall be required that it has within its organization, or has contracted on a full-time basis with at least one person who has the knowledge and background necessary to adequately provide industrial safety and health engineering services.

F. The service agent shall maintain adequate staff, and the staff shall be authorized to act for the service agent on all matters covered by the Workmen's Compensation Act and rules and regulations applicable thereto.

G. The service agent shall file copies of all contracts entered into with interlocal risk management agencies as they relate to the services to be performed. Such reports shall be kept confidential. The service agent will handle all claims, with dates of injury or disease, within the contract period until their conclusion, unless the service agent is relieved of that responsibility by a successor service agent.

H. Failure to comply with the provisions of the Workmen's Compensation Act shall be considered good cause for withdrawal of the approval to act as a service agent. Thirty days notice of withdrawal shall be given, and notice shall be served, by certified or registered mail, upon all interested parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§319. Penalty for Non-Compliance

A. Non-compliance with the provisions of this rule may result in suspension, revocation, or non-renewal of the Certificate of Authority issued by the Commissioner of Insurance pursuant to the provisions of Act 462 of the 1979 Session of the Louisiana Legislature.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

§321. Severability

A. If any of the provisions of this rule are held invalid, such invalidity shall not affect other provisions which can be given effect with the invalid item, and to this end the provisions of this rule are hereby declared severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 2 of 1950 and Act 462 of the 1979 Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:621 (July 1990).

Chapter 5. Rule Number 9—Pre-Licensing Insurance Education Advisory Council

§501. Purpose

A. The purpose of this rule is to implement Act 840 of the 1988 Regular Legislative Session by establishing curricula for courses of instruction required to be completed by applicants seeking insurance licenses in the state of Louisiana; to establish criteria for approval of providers of the courses of instruction; to establish a mechanism of examination and review of the performance and quality of the instruction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§503. Applicability and Scope

A. This rule shall apply to all applicants seeking a license as an insurance agent, broker, or solicitor who are required by statute to take an insurance examination. Further, this rule shall apply to the providers of the pre-licensing program and the instructors for said programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§505. Effective Date

A. The original effective date of this rule was July 1, 1989. The re-promulgated rule shall become effective upon final publication in the *Louisiana Register.*

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994), LR 27:2253 (December 2001).

§507. Course Requirements

A. Life, Health, and Accident

1. All applicants for life, health, and accident licenses as an agent are hereby required to complete a course of instruction with a minimum of 16 hours of supervised instruction in a structured setting. If applying for a combination life, health and accident license all applicants must complete the full 32 hours of life, health and accident instruction.

2. The curricula for the life instruction shall include the following:

a. insurance regulation;

b. general insurance;

c. life insurance basics;

d. life insurance policies;

e. life insurance policy provisions, options and riders;

f. annuities;

g. federal tax considerations for life insurance and annuities;

h. qualified plans.

3. The curricula for the health and accident instruction shall include the following:

a. insurance regulation;

b. general insurance;

c. health insurance basics;

d. individual health insurance policy provisions;

e. disability income and related insurance;

f. medical expense plans;

g. group health insurance;

h. dental insurance;

i. insurance for senior citizens and special needs individuals;

j. federal tax considerations.

B. Property and Casualty

1. All applicants for property and casualty licenses as agent, broker, or solicitor are hereby required to complete a course of instruction with a minimum of 32 hours of supervised instruction in a structured setting.

2. The curricula shall include the following:

a. insurance regulation;

b. general insurance;

c. property and casualty insurance basics;

d. dwelling policy (Louisiana specific);

e. homeowners ('91) policy;

f. auto insurance;

g. commercial package policy;

h. business owners ('89) policy;

i. workers' compensation insurance;

j. other coverage and options.

C. Satisfactory Completion of the Instructional Program. Upon completion of the prescribed course of instruction, the applicant shall be tested by the provider of the program.

D. Exemptions. The requirement for the completion of the instructional course does not apply to any applicant who is exempt from the requirement of an examination under R.S. 22:1167 or any applicant seeking authorization to write industrial fire insurance business only.

E. Concurrent Instructional Courses. When concurrent instructional courses for both life, accident, and health and property and casualty are conducted, the repetition of ethical practices and other topics which are redundant shall be waived. However, this does not reduce the minimum required hours of instructional training set forth by the statute.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994), LR 27:2253 (December 2001).

§509. Provider Requirements

A. Applications for program approval shall be submitted through the Department of Insurance to the Louisiana Insurance Education Advisory Council not less than 60 days prior to the expected use of the program. Each instructional provider applicant shall provide the information set forth herein with its application in the format required by the commissioner, as set forth herein.

1. Course outline, including a list of resource material used, training aids to be used, detail description of the program, and cost of the program to participants.

2. Schedule of locations where the instructional course will be offered and schedule of classes depicting time and dates. Any change in the schedule of locations, dates, or time of classes shall be filed with the council no later than three days prior to scheduled beginning date.

3. Completion of the department's pre-licensing provider application, for the initial certification of director/supervising instructor to be used in accordance with the requirements and qualifications of instructors set forth herein.

4. Description and location of the facilities to be used in accordance with the requirements set forth herein.

B. Once approved, the provider shall maintain detailed attendance records for all students for all classes for three years following completion of the classes. The records may be reviewed by the commissioner and the council.

C. The provider shall not allow credit for required hours for any class work which is not conducted under the direct supervision of the course instructor at the approved facility during scheduled classes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994), LR 27:2254 (December 2001).

§511. Instructor Qualifications

A. For the purpose of this Section, a distinction of types of providers must be acknowledged when prescribing the specific required qualifications for instructors.

1. An insurance trade association, as recognized by the commissioner, shall submit for approval the instructor who will be in a supervisory capacity. Said supervisory instructor shall provide the council with qualifications for instructors to be used during the tenure of the instructional course and shall assume the responsibility of assuring the quality of instructional course.

2. An insurance company admitted to do business in the state of Louisiana shall submit for approval the educational director holding educational responsibility for that company. Said director shall submit and have approved a supervisory instructor who may be delegated as the supervisory instructor in charge of the instructional course being given. Company personnel possessing expertise in specific areas of instructional topics will not have to be approved as an instructor. The director and/or supervising instructors holding educational responsibility for the company shall be responsible for assuring the quality of the instructional course.

3. The instructor charged with the responsibility for the instructional course at an accredited public or private college or university shall require approval by the commissioner and the council, based in part on the educational background of the instructor and the insurance experience said instructor may possess.

4. Other organizations recommended by the council and authorized by the commissioner shall have a supervising instructor certified and assigned the responsibility of conducting the instructional courses. The approved supervising instructor shall be responsible for any other instructor or guest instructor and shall be responsible for assuring the quality of the instructional course.

5. All instructors must possess the necessary qualifications to enable them to teach the program and to present the instructional material. Special consideration may be granted by the commissioner or the council with commissioner's approval, where it is felt that the specific background of the instructor warrants such consideration. The qualifications for instructors shall include, as a minimum, the following:

a. for supervising instructors, five years of insurance and/or educational experience satisfactory to the commissioner and council;

b. instructors will not be qualified who have received disciplinary action for insurance related practices by the Louisiana Insurance Department, the Insurance Department of another state, or any similar regulatory body or court;

c. the commissioner shall have the authority to waive this requirement after a public hearing to determine the applicant's qualifications has been held and findings of such hearing warrant such a waiver.

6. For all instructors, except those specified in §511.A.2, the supervising instructor shall obtain and submit a Pre-Licensing Instructor Application form for each instructor who will participate in the instructional course.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994), LR 27:2254 (December 2001).

§513. Training Facility Requirements

A. The provider shall furnish training facility descriptions when applying to become an approved provider of an instructional program. Minimum acceptable training facility characteristics are:

1. an atmosphere conducive to educational presentation, including good housekeeping, controlled environment as to heating and cooling, proper lighting, proper furnishing;

2. the facility shall be easily accessible and secure for the safety of the student;

3. the instructional area of the facility should be for the exclusive use for the instructional course while in session;

4. readily accessible human needs should be considered when selecting a facility;

5. training aids, overhead viewing equipment availability, and a proper visual layout of the classrooms should be addressed;

6. in the event that proper facilities are not available as previously described, the provider shall furnish specific description of the available facility for approval by the commissioner or the council.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§515. Licensing Procedure of Applicant

A. The commissioner, Insurance Department staff, and the Insurance Education Advisory Council shall have the authority to visit a training facility and review the provider's program at any time. Said visits can include the review of curriculum records, review of attendance records, and observation of instructional sessions in progress, which must be accessible at all times during instructions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§517. Course Completion

A. The required instructional course must be completed prior to the applicant's taking the insurance licensing examination administered by the Insurance Department. The applicant must have successfully completed the instructional course no more that 12 months prior to taking the examination.

B. The supervising instructor of the designated official of the program provider shall provide an original list reflecting each individual who has successfully completed the required course and shall provide a certificate of successful completion to each participant. The list shall contain the name, address, and Social Security number of all successful individuals and must be forwarded to the Department of Insurance within 15 working days of course completion.

C. The provider must maintain computer records of course completion in a format compatible with Insurance Department specifications to facilitate the electronic reporting and transfer of attendance information from the provider to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994), LR 27:2254 (December 2001).

§519. Fees

A. A certification fee of $250 will be charged to each applicant seeking certification of a program of instruction to qualify individuals to take an insurance agents licensing examination in the state of Louisiana. The Commissioner of Insurance may require the posting of a fidelity bond sufficient to safeguard the interests of consumers of this service; however, in no event shall such bond exceed $100,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§521. Complaints

A. The commissioner or the council, at the direction of the commissioner, shall review all complaints lodged against the provider or instructor of the program, and such complaints shall be lodged by a notarized affidavit of a student of said course. A hearing may be called for the purpose of investigating the complaint and/or taking necessary action to resolve the complaint. Any disciplinary action required shall be taken by the commissioner, in accordance with Part 29 of the *Louisiana Insurance Code*, R.S. 22:1351-67.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§523. Violations

A. Pursuant to the authority of the commissioner, the approval of a provider's program of instruction may be suspended or revoked for violation of the rule set forth herein and/or any pertinent provisions of the *Louisiana Insurance Code*, R.S. 22:1351-67.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

§525. Expiration Date

A. The rule set forth herein shall be reviewed by the Insurance Education Advisory Council every three years to determine if modifications to the rule are necessary.

B. In the event modification of this rule is thought to be necessary, a notice of a meeting to consider the modifications recommended by the Insurance Education Advisory Council shall be given in accordance with the provisions of R.S. 22:1354(C).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1191.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 15:548 (July 1989), amended LR 20:1388 (December 1994).

Chapter 7. Rule Number 10—Continuing Education

§701. Purpose

A. The purpose of this regulation is to protect the public, maintain high standards of professional competence in the insurance industry, and maintain and improve the insurance skills and knowledge of agents, brokers, and solicitors licensed by the Department of Insurance. This shall be accomplished by prescribing: minimum standards of education in approved subjects that a licensee must periodically complete; procedures and standards for the approval of such education; and a procedure for establishing that continuing education requirements have been met.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§703. Basic Requirements

A. As a condition for the continuation of a license, a licensee must furnish the Department of Insurance, prior to the licensing renewal date, proof of satisfactory completion of approved subjects or courses having the required minimum hours of continuing education credit during each two-year licensing period.

1.	Life-health license only	16 hours
2.	Property-casualty	24 hours
3.	Combination of both P-C & L-H licenses	12 hours life-health 20 hours property-casualty
4.	Bail bond license	12 hours

B. Failure to fulfill the continuing education requirements prior to the filing date for license renewal shall cause the license to write insurance to lapse. For a period of three years from the date of lapse of the license, the license may be renewed upon proof of fulfilling all continuing education requirements through the date of reinstatement and payment of all fees due. If the license has lapsed for more than three years, the license may be renewed only by fulfilling the requirements for issuance of a new license.

C. Property-casualty insurance agents shall complete 24 hours of approved instruction prior to each license renewal. Life-health insurance agents shall complete 16 hours of approved instruction prior to each license renewal. Each course to be applied toward satisfaction of the continuing education requirement must have been completed within the two-year period immediately preceding renewal of the license. Until May 1, 2003, up to 10 excess hours, acquired during the previous renewal period, may be carried forward and applied to the continuing education requirement.

D. Agents authorized to write both life-health and property-casualty insurance shall complete 20 hours of approved property-casualty instruction prior to each property-casualty license renewal. These agents shall also complete 12 hours of approved life-health instruction prior to each life-health license renewal. Each course to be applied toward satisfaction of the continuing education requirements must have been completed within the two-year period immediately preceding renewal of the license. Until May 1, 2003, up to 10 excess hours, acquired during the previous renewal period, may be carried forward and applied to the continuing education requirement.

E. Duplication of the same courses offered by the same provider will not be accepted as proof of compliance for continuing education requirements during the same renewal period.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994), LR 27:561 (April 2001).

§705. Applicability

A. This regulation applies to all resident agents, brokers, and solicitors licensed by the Department of Insurance. Further, this rule shall apply to the providers of continuing education programs and instructors for such programs.

B. This regulation applies to all nonresident agents, brokers, and solicitors licensed by the Department of Insurance. However, nonresident licensees subject to continuing education requirements in their home state shall be exempt from this regulation.

C. This requirement for the completion of continuing education shall not apply to the following:

1. specialty classes of licenses including industrial fire, industrial life and health, credit life, credit health and accident, credit property, accidental death and dismemberment and/or vendor single interest which is written solely in connection with credit transactions, title, travel, baggage, auto clubs, home service, and other limited licenses;

2. licensees that are at least 65 years of age and have a minimum of 15 years experience as an agent, broker, or solicitor and are also either:

a. no longer actively engaged in the insurance business as an agent, broker or solicitor and who is receiving Social Security benefits, if eligible; or

b. actively engaged in the insurance business as an agent, broker or solicitor and who represents or operates through a licensed Louisiana insurer;

3. a new licensee who has completed an approved prelicensing education course is exempt from continuing education requirements under this rule for the first license renewal only. Thereafter, the new licensee will be subject to all continuing education requirements.

D. If a licensee is unable to comply with continuing education requirements during the licensing period because of a disability, medical condition or similar reason, the commissioner may waive the continuing education requirements or may require the licensee to complete the required number of credit hours through correspondence courses. The following is necessary to request a waiver:

1. a current physician's statement supporting the licensee's disability/illness;

2. a description, in the licensee's own words of the disability/illness and the reason said disability/illness prevented the licensee from attending a classroom or completing a home study (correspondence) course.

E. The Department of Insurance anticipates and expects that licensees will maintain high standards of professionalism in selecting quality education programs to fulfill the continuing education requirements.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:856 (October 1990), amended LR 17:790 (August 1991), LR 20:1392 (December 1994), LR 27:562 (April 2001).

§707. Insurance Education Advisory Council

A. The Insurance Education Advisory Council, comprised of representatives from each segment of the insurance industry, shall be appointed by the Commissioner of Insurance to perform the following duties:

1. approve or disapprove programs as per the standards of this regulation and assign the number of continuing education hours to be awarded to programs that are approved;

2. consider applications for exceptions as permitted under rule of this regulation; and

3. consider other related matters as the commissioner may assign.

B. The Department of Insurance shall provide all members of the Insurance Education Advisory Council timely written notice of all council meetings. The members present at any meeting of the Insurance Education Advisory Council shall be deemed to be a quorum for purposes of acting to perform the duties of the council pursuant to this regulation. Matters before the Insurance Education Advisory Council may be decided by a majority of those members present. In the event of a tie vote, the chairman shall vote to break the tie.

C. Decisions or rulings of the Insurance Education Advisory Council in performance of the duties set forth herein shall have the effect of decisions or rulings of the Department of Insurance, but are subject to review and approval by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§709. Program Requirements

A. All continuing education programs are subject to review and approval by the Insurance Education Advisory Council and certification by the commissioner. Each program must be submitted to the Insurance Education Advisory Council in accordance with this rule on forms promulgated by the commissioner (§733) not less than 60 days prior to the expected use of the program.

B. If a program is not approved in advance of presentation, a retroactive application for credit may be submitted to the Insurance Education Advisory Council within 60 days of completion of the course on forms promulgated by the commissioner (§733). All correspondence courses or individual study programs must be approved and certified in accordance with this rule prior to being offered to licensees for continuing education credit.

C. Any course which has not been approved by the Insurance Education Advisory Council and certified by the commissioner before the date on which it is to be presented shall not be represented or advertised on any manner as "approved" for continuing education credit.

D. Courses Which Qualify

1. A specific course will qualify as an acceptable continuing education program if it is a formal program of learning which contributes directly to the professional competence of a licensee. It will be left to each individual licensee to determine the course of study to be pursued. All programs must meet the standards outlined in the rule.

2. Subjects Which Qualify

a. The following general subjects are acceptable as long as they contribute to the knowledge and professional competence of an individual licensee as an agency, broker, or solicitor and demonstrate a direct and specific application to insurance:

i. insurance and risk management;

ii. insurance laws, regulations and ethics;

iii. courses in economics, business, management, computers, finance, taxes and laws which relate specifically to the insurance business;

iv. any other such subjects which may be related to the insurance industry. This may include but will not be limited to subjects such as securities and finance.

b. Areas other than those listed above may be acceptable if the licensee can demonstrate that they have direct and specific application to insurance and contribute to professional competence and otherwise meet the standards set forth in this regulation. The responsibility for substantiating that a particular program meets the requirements of this regulation rests solely upon the licensee.

E. Courses which do not qualify:

1. any course used to prepare for taking an insurance or securities licensing examination;

2. general computer courses not specifically related to the insurance business;

3. motivation, psychology, communications, or sales training courses;

4. general business courses not specifically related to the insurance business;

5. any program not directly and specifically applicable to the insurance business.

F. In order to qualify for credit, the following standards must be met by all continuing education courses.

1. Course Development

a. The program must have significant intellectual or practical content to enhance and improve the insurance knowledge and professional competence of participants.

b. The program must be developed by persons who are qualified in the subject matter and instructional design.

c. The program content must be current and up to date.

2. Course Presentation

a. Instructors must be qualified, both with respect to programs content and teaching methods. Instructors will be considered qualified if, through formal training or experience, they have obtained sufficient knowledge to instruct the course competently.

b. The number of participants and physical facilities must be consistent with the teaching method specified.

c. All programs must include some means for evaluating the quality of education provided.

G. Any provider organization intending to provide classes, seminars, or other forms of instruction as approved subjects shall apply for program approval on following forms promulgated by the commissioner for approval by the Insurance Education Advisory Council.

1. For the initial approval of a provider organization, §737.Continuing Education Provider Application must be submitted with appropriate history and résumé of the organization necessary to establish credibility as a CE provider. Section 737 also lists additional information which must be provided. The provider applicant must substantiate the experience and ability of the provider organization to provide quality CE programs.

2. Section 733—Request for Program/Course Approval

3. Division A and B providers must furnish an outline of the subject matter to be covered with time specifications for presentation.

4. Division C, D, and E providers must furnish an actual copy of the student workbook and materials, along with time specifications for presentation and a list of resource material used, training aids used, and the method of presentation.

a. If a provider submits a course with materials published by a recognized publisher of insurance education materials, each and every student must be provided with a complete original text from that publisher as part of the registration fee for the approved continuing education course. This text shall be retained by the student and shall not be returned or resold to the provider. No substitute texts, outlines, summaries or copyright infringements will be allowed.

b. Proprietary student materials of the provider must be submitted to the Insurance Education Advisory Council for approval on their own merits and must not infringe on the copyright of existing materials.

5. If multiple presentations of a program will be made, a §735.Continuing Education Provider Training Schedule must be included. The outline shall include schedule and description of locations where the program will be offered, including dates and times. Any change in this schedule of locations, dates, or time of classes shall be filed with the Department of Insurance not less than three days prior to the scheduled beginning date.

6. Section 739.Continuing Education Instructor Application along with résumés and qualifications of the instructors must be submitted in compliance with §713.

7. Other information supporting the request for approval, as outlined in this rule, must be provided to the Insurance Education Advisory Council for consideration of the course approval. The submission must provide the council with sufficient information to substantiate that the course provides an appropriate subject matter, of sufficient degree of advanced study, with quality written student materials, and taught by quality experienced instructors.

H. The submission shall include a statement of the method used to determine whether there has been a positive achievement of education on the part of the agent being certified. Such method may be a written examination, a written report by the agent, certification by the providing organization of the agent's program attendance or

completion, or other method approved by the council as appropriate for the subject.

I. Each course application shall be accompanied by a nonrefundable application fee of $25.

J. Upon receipt of such material, the Insurance Education Advisory Council will approve or deny the course or program as qualifying for credit, indicate the number of hours that will be awarded for approved subjects, and refer the class, seminar, or program to the commissioner for his certification. In cases of denial, the Insurance Education Advisory Council shall furnish a written explanation of the reason for such action.

K. The department will provide, upon request, a list of all programs currently available which the Department of Insurance has certified.

L. Certification of a program may be effective for a period of time not to exceed three years or until such time as any material changes are made in the program. After that time the program must be recertified by the Insurance Education Advisory Council.

M. Licensees who attend programs that are not approved for CE credit because of a small attendance by Louisiana licensees, may apply to the Insurance Education Advisory Council for individual approval of the course by complying with the standard submission procedures outlined in this rule and the payment of the $25 submission fee.

N. The Department of Insurance may accept the Midwest Zone Standard Continuing Education Filing Forms or any other uniform, standardized forms approved by the Department of Insurance and the necessary attachments as the forms required for approval of courses submitted by a nonresident continuing education provider, for courses previously awarded credit by the continuing education provider's home state. Courses that have not previously been awarded credit in the provider's home state must be approved pursuant to all other provisions of this rule.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:856 (October 1990), amended LR 17:790 (August 1991), LR 20:1392 (December 1994), LR 27:562 (April 2001).

§711. Provider Requirements

A. All continuing education provider organizations are subject to review and approval by the Insurance Education Advisory Council and certification by the commissioner. CE providers must demonstrate their ability to provide quality education programs with appropriate subjects, quality student materials, and instructors with the knowledge, experience, and teaching skills necessary to improve the professional level of licensees. Applications for provider approval shall be submitted through the Department of Insurance to the Louisiana Insurance Education Advisory Council not less than 60 days prior to the first submission for program approval. Each education provider applicant shall provide all necessary information in the format set forth in this rule. The provider application shall include:

1. a completed §737.Continuing Education Provider Application with the additional information listed;

2. qualifications of the education provider organization including, but not limited to, the past experience of the provider in conducting insurance education programs, sufficient to establish that the organization will provide quality CE courses;

3. completion of §739.Continuing Education Instructor Application and résumé in accordance with the requirements and qualifications of instructors set forth in this rule for the initial certification of the director/supervising instructor;

4. Section 745.Administrative and Reporting Requirements Survey and supporting materials necessary to establish that the provider will comply with all reporting requirements of this rule and provide students with the administrative support necessary to comply with CE requirements;

5. the complete name, address, and description of the training facilities to be used sufficient to establish compliance with §715 of this rule requiring adequate facilities for proper training;

6. a schedule of registration fees and student costs to participate in programs;

7. program submission as outlined in §709 including, but not limited to, a complete copy of all student materials or course outline used, list of resource materials, detailed description of programs, detailed time distribution of presentation, résumé, and qualifications of specific instructors who will teach each program, and class schedules and locations. Refer to §709 for details.

B. Insurance agent, broker, or solicitor organizations, their parent or subsidiary organizations will not be approved as a continuing education provider for the primary purpose of providing continuing education for their licensed employees.

C. Each provider application shall be accompanied by a nonrefundable application fee of $250.

D. Once approved, the provider shall maintain detailed attendance records for all students for all classes for three years following completion of all classes. Records must be maintained in computer format compatible with Insurance Department specifications to facilitate the electronic reporting and transfer of attendance information from the provider to the Insurance Department. The provider must complete §745—Administrative and Reporting Requirements Survey to establish these capabilities, and must work with Insurance Department computer personnel to maintain the required computer reporting records. The provider must also maintain a physical office facility adequate for the proper storage of records, and administrative staff necessary to facilitate the proper administration of CE requirements for student licensees. Provider records may be reviewed by the commissioner and the council.

E. The provider shall not allow credit for required hours for any work which is not conducted under the direct supervision of the course instructor at the approved facility during scheduled classes.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§713. Instruction Requirements

A. Insurance trade associations, insurance companies, accredited public colleges and universities, and nationally recognized insurance professional designation programs, as recognized by the commissioner (Division A and B providers), shall submit for approval the education director who will be certified to serve in a supervisory capacity. The education director shall be assigned the responsibility for verifying the qualifications of any other instructors used by the provider and shall be responsible for assuring the quality of all education courses.

B. Other organizations recommended by the council and authorized by the commissioner shall have an education director certified. The education director must submit a §739 form for each instructor who will participate in any course conducted by the provider. The Insurance Education Advisory Council must approve each instructor and course. The approved education director shall be responsible for any other instructor or guest instructor and shall be responsible for assuring the quality of all education courses.

C. All instructors must possess the necessary qualifications to enable them to teach the program and to present the instructional material. Special consideration may be granted by the commissioner or the council, with the commissioner's approval, where it is felt that the specific background of the instructor warrants such consideration. The qualifications for instructors shall include as a minimum the following:

1. for education directors and supervising instructors, five years of insurance and/or education experience satisfactory to the commissioner and council;

2. instructors will not be qualified who have received disciplinary action for insurance related practices by the Louisiana Insurance Department, the insurance department of another state, or any similar regulatory body or court;

3. expertise and experience in the specific subject area to be taught, professional designations, or other credentials which indicate a technical mastery of the subject;

4. experience in teaching, instruction, or public speaking which indicate an ability to present the subject matter.

D. The commissioner shall have the authority to waive this requirement after a public hearing, to determine the applicant's qualifications, has been held and findings of such hearing warrant such a waiver.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§715. Training Facility Requirements

A. The provider shall furnish training facility descriptions when applying to become an approved provider of an instructional program. Minimum acceptable training facility characteristics must be maintained at all times.

B. An atmosphere conductive to the education presentation shall be maintained, including good housekeeping, controlled environment as to heating and cooling, proper lighting, and proper furnishings.

C. The facility shall be easily accessible and secure for the safety of the student.

D. The instructional area of the facility should be for the exclusive use for the instructional course while in session.

E. Readily accessible human needs should be considered when selecting a facility.

F. Training aids, overhead viewing equipment availability and a proper visual layout of the classrooms should be addressed.

G. In the event that proper facilities are not available as previously described, the provider shall furnish specific description of the available facility for approval by the commissioner or the council.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:858 (October 1990), amended LR 17:792 (August 1991), LR 20:1395 (December 1994), LR 27:563 (April 2001).

§717. Rule 10.10. Measurement of Credit

A. Professional education courses shall be credited for continuing education purposes in full hours only. The number of hours shall be equivalent to the actual number of contact hours, number of hours in the classroom in instruction or participation. Each hourly period must include at least 50 minutes of continuous instruction or participation. For this purpose, a one-day program will be granted eight hours credit if the total lapsed time is approximately eight hours and the contact time is at least 400 minutes.

B. University or college upper division credit or noncredit courses shall be evaluated as follows:

1. each semester system credit hour shall not exceed eight hours toward the requirement;

2. each quarter system credit hour shall not exceed four hours.

The final number of credits shall be determined by the Insurance Education Advisory Council.

C. Credit hours for individual study programs shall be determined by the Insurance Education Advisory Council. The council shall determine a reasonable number of CE credit hours which will be subject to a limitation that the

licensee may only receive credit for a maximum of 50 percent of the required CE hours from individual study programs.

D. The total continuing education credit hours required for license renewal are limited by the following percentages for each of the following education divisions.

Continuing Education Credit Chart		
100%	Division A	National Professional Designations CPCU, CLU, ARM CHFC, CIC, etc.
100%	Division B	Agent Associations Colleges and Universities Insurance Companies
100%	Division C	Proprietary Schools
50%	Division D	Individual Study
25%	Division E	Miscellaneous General Interest Public Speaking General Interest Association Programs

E. Example of Continuing Education Credit Chart—§717.D.

1. Single License Property-Casualty. Continuing education credit hours required: 24 CE hours Maximum CE hours for each division:

a. A Division hours 24;

b. B Division hours 24;

c. C Division hours 24;

d. D Division hours 12;

e. E Division hours 4;

f. F Division hours 4.

F. The number of continuing education credit hours will be limited to a maximum of eight hours per day of instruction. Continuing education credit hours will not be approved for programs conducted during meal functions unless the education presentation is completely separate from the meal function. The maximum number of continuing education credit hours which will be approved for any single course will be 24 credit hours for property-casualty courses and 16 credit hours for life-health courses.

G. Qualified continuing education programs earning a graduate level professional designation such as CPCU, CLU, ChFC, etc., will be subject to special rules as contained in this paragraph. Licensees which successfully pass a qualified graduate level national designation program examination shall earn 24 continuing education credit hours for property-casualty courses and 16 continuing education credit hours for life-health courses.

H.1. Members of state or national professional associations may be granted four continuing education credits each year for actively participating in a state or national insurance association in one of the following methods:

a. attend a formal meeting of a state or national association where a formal business program is presented and attendance is verified in a manner consistent with the provisions of Rule 10;

b. serve on the board of directors or a formal committee of a state or national chapter of the association, and actively participate in the activities of the board or committee;

c. participate in industry, regulatory, or legislative meetings held by or on behalf of a state or national chapter of the association; or

d. participate in other formal insurance business activities of a state or national chapter of the association.

2. In order to qualify for continuing education credit under this provision, members must attend at least 4 hours of qualified activities. Continuing education credit shall be given as one 4 hour increment each year from the association in a manner consistent with the provisions of Rule 10. The association shall be responsible for verifying attendance or participation of members for all events where continuing education credit is given under the terms of this provision. Attendance at meetings which are otherwise approved for continuing education credit do not qualify under the terms of this provision. The association shall file with the department for approval of a "course number" which shall be shown on all continuing education certificates issued under the terms of this provision.

3. Continuing education credit for membership in a bail bond association may only be applied towards renewal or reinstatement of a bail bond producer license. Continuing education credit for membership in a life, health and accident, property or casualty type association may only be applied towards renewal or reinstatement of a similar producer license.

4. Licensed producers may receive multiple member association certifications due to membership in more than one association; however, the licensee may only apply one membership certification to each renewal of his license. This certification must have been issued within the two year period immediately preceding renewal of the license.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Louisiana Regular Legislative Session; R.S. 22: 1193; and the Louisiana Administrative Procedure Act, R.S. 49: 950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:858 (October 1990), amended LR 17:792 (August 1991), LR 20:1395 (December 1994), LR 28:510 (March 2002), LR 31:1096 (May 2005).

§719. Controls and Reporting

A. Upon completion of a class, program, or course of study, the instructor or sponsoring organization shall, within 60 days of completion of the course, provide a certificate of completion (§741, Appendix 5) to each individual who satisfactorily completes the class, program, or course of study. The certificate of completion shall bear the seal of the education provider organization. The provider must also maintain computer records of course completion in a format compatible with Insurance Department standards. Providers must report course completion records to the Insurance Department as requested.

B. Licensees must submit with the application for renewal of a license a signed continuing education statement, under oath, on a form prescribed by the department (§743, Appendix 6 to this regulation), listing the courses that have been taken in compliance with this regulation copies of their certificate of completion (§741, Appendix 5 to this regulation) for each of the courses completed.

C. The original certificates of completion for each educational program or course shall be retained by the licensee as evidence of completion of the program or course for the most recent two-year renewal period. The licensee shall provide the Department of Insurance with these original certificates as proof of completion upon request of a formal audit.

D. The continuing education statements submitted by licensees will be reviewed by the Department of Insurance and may be verified by a formal audit by the department. If a continuing education statement submitted by an applicant for license renewal, as required by this regulation, is not approved, the applicant shall be notified and administrative action shall be taken.

E. The responsibility for establishing that a particular course or other program for which credit is claimed is acceptable and meets the continuing education requirements set forth in this regulation rests solely on the licensee.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:858 (October 1990), amended LR 17:792 (August 1991), LR 20:1395 (December 1994), LR 27:563 (April 2001).

§721. Program Review—Disciplinary Action

A. The commissioner, Insurance Department staff, and the Insurance Education Advisory Council shall have the authority to visit a training facility and review the provider's program at any time. Said visits can include the review of curriculum records, review of attendance records, and observation of instructional sessions in progress, which must be accessible at all times during instruction.

B. The certificate of a provider or program may be suspended by the commissioner if he determines that:

1. the program teaching method or program content no longer meets the standards of this regulation, or has been significantly changed without notice to the commissioner for its recertification; or

2. the provider certified to the commissioner that an individual had completed the program in accordance with the standards furnished for certification or completion of the program, when in fact the individual has failed to do so; or

3. individuals who have satisfactorily completed the program of study in accordance with the standards furnished for certification or completion were not so certified by the provider or instructor; or

4. there is other good and just cause why certification should be suspended.

C. Suspension shall be subject to notice and hearing in accordance with Part 29 of the *Louisiana Insurance Code*, R.S. 22:1351-67.

D. Reinstatement of a suspended certification may be made upon the furnishing of proof, satisfactory to the commissioner, that the conditions responsible for the suspension have been corrected.

E. The commissioner, or the council at the direction of the commissioner, shall review all complaints lodged against a provider or instructor of a program. Such complaints shall be lodged by a notarized affidavit of a student of said course. A hearing may be called for the purpose of investigating the complaint and/or taking necessary action to resolve the complaint. Any disciplinary action required shall be taken by the commissioner in accordance with Part 29 of the *Louisiana Insurance Code*, R.S. 22:1351-67.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§723. Rule 10.13 Credit for Individual Study Programs

A. Credit hours for individual study programs shall be determined by the Insurance Education Advisory Council. The council shall determine a reasonable number of CE credit hours which will be subject to a limitation that the licensee may only receive credit for a maximum of 50 percent of his required CE hours from individual study programs.

B. Insurance companies admitted to do business in the state of Louisiana, insurance trade associations as recognized by the commissioner, and accredited public or private colleges or universities may be recognized as providers of independent study courses. Other organizations recommended by the council and authorized by the commissioner may be approved as providers of independent study courses if they meet one of the following qualifications:

1. five years or more experience as a recognized insurance education provider of independent study courses;

2. accreditation by a national education organization. All individual study programs must be submitted for approval by the organization which complies or publishes the course materials. All individual study courses must be approved prior to being offered to licensees for continuing education credit. Any such course approval is not transferable to any other entity.

C. Continuing education credit for individual study programs must be applied to the current license renewal and may not be carried over to subsequent license renewals. No individual study program will be certified for more than 24 continuing education credit hours for property-casualty courses or 16 continuing credit hours for life-health courses.

D. Qualified individual study program providers (example: national publishing companies) may not contract their provider status to other CE providers. The integrity of

materials and testing are the responsibility of the approved provider and must be maintained under their direct control. Local CE providers may act as vendors or marketing agents of approved individual study program providers as long as the provider controls the materials and testing.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Louisiana Regular Legislative Session; R.S. 22: 1193; and the Louisiana Administrative Procedure Act, R.S. 49: 950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:859 (October 1990), amended LR 17:793 (August 1991), LR 20:1396 (December 1994), LR 28:511 (March 2002), LR 31:1096 (May 2005).

§725. Credit for Service as Instructor

A. One hour of continuing education credit will be awarded for each hour completed as an instructor or discussion leader, provided the class or program is certified by the commissioner and meets the continuing education requirements of those attending.

B. Credit for instruction will only be granted once for each course or program, not for successive presentation of the same course.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§727. Effective Date

A. This regulation shall be effective December 20, 1994.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§729. Separability

A. If any provision of this regulation is for any reason held to be invalid, the remainder of the regulation shall not be affected thereby.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§731. Periodic Review

A. The rule set forth herein shall be reviewed by the Insurance Education Advisory Council every three years to determine if modifications to the rule are necessary.

B. In the event modification of this rule is thought to be necessary, a notice of a meeting to consider the modifications recommended by the Insurance Education Advisory Council shall be given in accordance with the provisions of R.S. 22:1354.C.

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:859 (October 1990), amended LR 17:793 (August 1991), LR 20:1397 (December 1994), LR 27:563 (April 2001).

§733. Appendix 1—Request for Program/Course Approval

REQUEST FOR PROGRAM/COURSE APPROVAL

SUBMIT THIS FORM IN DUPLICATE NAIC APPROVED

REQUEST FOR APROVAL OF CONTINUING EDUCATION CREDIT IN THE STATE OF_____

Name and Address of Entity/ Sponsor Submitting Course

Name and Telephone Number of Contact Person
Name_____
1 - ( ) _____
1 - (800) - _____

Course Title/Name_____
Date of Course _____Start Time _____ End _____
☐ If course will be repeated, check and attach location scheduled.
Location _____ City _____
Primary Instructor Telephone _____
_____

Method of Instruction		Method of Determining Successful Completion	
☐ Classroom/Leisure	☐ Correspondence	☐ Final Exam — Supervised	
☐ Seminar	☐ Prof. Assoc.	☐ Final Exam — Correspondence	
☐ College University	☐ Employee Trng.	☐ Completed Text	
☐ Other _____	☐ Instructor	☐ Instructor	
Hours of Instruction/ Contact Classroom Hours _____		☐ Attendance	☐ Other _____
Credit Hours Requested		Course Concentration	
☐ Life/Health & Accident/Annuities Variable		☐ Product	☐ Management
☐ Property/Casualty		☐ Marketing	☐ Other _____
☐ Either	☐ General	☐ General Ins. Principles	

States that have approved this course (if filing is pending, place "P" in the hours column):

Dept.	Hours	Dept.	Hours	Dept.	Hours	Dept.	Hours	Dept.	Hours	Dept.	Hours
DE	_____	IA	_____	MN	_____	NM	_____	SD	_____	LA	_____
GA	_____	KS	_____	MS	_____	ND	_____	TN	_____	_____	_____
IL	_____	MA	_____	NE	_____	OR	_____	WA	_____	_____	_____

Names and Signatures of Instructors Authorized to sign Certificate of Completion:

_____ Name (Typed or Printed) _____ Signature

_____ Name (Typed or Printed) _____ Signature

Application for Credit — Each course sponsor shall certify the hours of the study, on the average, required to successfully complete each course. Credit will be granted in accordance with A) State Regulation, B) review by the Department of Insurance. The Provider agrees to C) maintain a record for not less than three years (five years for Georgia) for persons attending each course; D) provide Certificate of Attendance Completion with hours earned to successful students upon completion and E) comply with the regulations of the Department of Insurance in conducting Continuing Education courses.

Attachments — 1) Attach course description, "outlines," Continuing Education Objectives;" copy of "Certificates of Attendance Completion," promotional material, types of policies, forms, etc. that may be used in considering the submitted course. 2) Attach Instructor biographical statement, including typed names and signatures. 3) Text must be filed in: ("REQUIRED FOR APPROVAL").

Submitted by _____ _____ _____
Name (Typed or Printed) Signature Date

_____ _____
Title Organization

DEPARTMENT USE ONLY

☐ Course approved for _____hours
☐ Not approved
Comments: _____
_____
_____
_____

☐ Life/Acc. & Health/Annuities/Variable
☐ Property/Casualty
☐ Either ☐ General

_____DEPARTMENT OF INSURANCE

§735. Appendix 2—Continuing Education Provider Training Schedule

CONTINUING EDUCATION PROVIDER TRAINING SCHEDULE

TRAINING PROVIDER
TRAINING LOCATION
TELEPHONE NUMBERS
INSTRUCTOR(S)
DATE_____ TIME_____ LOCATION_____

_____
SIGNATURE OF SUPERVISING INSTRUCTOR

Rev. 8/1/94

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§737. Appendix 3—Continuing Education Provider Application

CONTINUING EDUCATION PROVIDER APPLICATION

TO: STATE OF LOUISIANA
COMMISSIONER OF INSURANCE
LICENSING DIVISION
P.O. BOX 94214
BATON ROUGE, LA 70804-9214

APPLICATION FOR APPROVAL AS A PROVIDER OF CONTINUING EDUCATION COURSES PURSUANT TO ACT 428 OR THE 1989 REGULAR LEGISLATIVE SESSION.

NAME OF PROVIDER_____
ADDRESS_____
CONTACT PERSON_____
TELEPHONE NUMBER_____

ATTACH THE FOLLOWING:

1. COURSE OUTLINE (GIVING TIME ALLOTTED TO EACH SUBJECT)
2. LIST OF RESOURCE MATERIAL
3. RÉSUMÉ OF SUPERVISING INSTRUCTOR OR DIRECTOR
4. DESCRIPTION OF TRAINING FACILITIES TO BE USED
5. CLASS SCHEDULES AND LOCATIONS
6. COST OF PARTICIPATION
7. APPENDIX 7 (ADMINISTRATIVE AND REPORTING REQUIREMENTS SURVEY)

_____
(PROVIDER)

_____
(SIGNATURE OF PROVIDER REPRESENTATIVE)

_____
(DATE)

FOR DEPARTMENT USE ONLY

APPROVED BY:
_____DATE:_____

DISAPPROVED BY:
_____DATE:_____

Rev. 8/1/94

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§739. Appendix 4—Continuing Education Instructor Application

CONTINUING EDUCATION INSTRUCTOR APPLICATION

APPLICATION FOR APPROVAL AS AN INSTRUCTOR OF CONTINUING EDUCATION INSURANCE COURSES PURSUANT TO ACT 428 OF THE 1989 REGULAR LEGISLATIVE SESSION.

PROVIDER_____
INSTRUCTOR_____
ADDRESS_____
TELEPHONE_____
OCCUPATION_____
Qualifications_____
_____
_____
_____

I have_____or have not_____received disciplinary action for insurance related practices by the Louisiana Insurance Department, the Insurance Department of another state, or any similar regulatory body or court.

_____
Signature of Instructor

_____
Signature of Supervising Instructor

FOR DEPARTMENT USE ONLY
APPROVED BY: _____DATE: _____
DISAPPROVED BY: _____DATE: _____
Rev. 8/1/94

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§741. Appendix 5—Continuing Education Certificate

CONTINUING EDUCATION CERTIFICATE

This Certificate of Completion will be accepted as evidence that the person named herein has complied with the Continuing Education requirements mandated by the Department of Insurance in the state of LOUISIANA

_____
Name of Education Provider

_____
Provider Authorization No.

_____	_____	_____
Name of Agent	Agent License No.	Social Security No.
_____		_____
Course Title		Course Number
_____		_____
Course Completion Date		Credit Hours Earned
_____		_____
Signature of Authorized Instructor		Date:
_____		_____
Signature of Agent		Date:

The Department of Insurance makes the agent responsible for using this certificate to meet state requirements.

ATTENTION: A copy of this Certificate must be filed with the Department of Insurance.

Rev. 8/1/94

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§743. Appendix 6—Continuing Education Statement

CONTINUING EDUCATION STATEMENT

I, hereby certify under penalty of perjury that I have completed the required number of hours for renewal of my license as required by Rule No. 10 of the Department of Insurance.

Course Title	Course Number	Completion Date	Education Provider	Hours Earned
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____

ALL CREDITS MUST BE APPROVED BY THE LOUISIANA DEPARTMENT OF INSURANCE.

I, hereby certify that the information provided above, to the best of my knowledge, is complete and accurate and that I did in fact attend the above listed courses for the number of hours indicated.

DATED this _____day of _____, 19_____.

_____
(Signature)

_____
(Name, Typed or Printed)

_____
(Social Security Number)

_____
(Agent's License Number)

Rev. 8/1/94

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

§745. Appendix 7—Administrative and Reporting Requirements Survey

LOUISIANA INSURANCE EDUCATION ADVISORY COUNCIL CONTINUING EDUCATION PROVIDERS ADMINISTRATIVE AND REPORTING REQUIREMENTS SURVEY

PROVIDER NAME:_____

ADDRESS: _____

1. How long has the organization provided insurance continuing education?

Explain:_____

_____

_____

2. Staff Levels:

Please provide the following information for all staff (including administrative) involved with providing continuing education in Louisiana.

STAFF NAME	JOB DESCRIPTION POSITION	AVERAGE HOURS/WEEK CE LOUISIANA
1._____		
2._____		
3._____		
4._____		
5._____		

3. Do you have a commercial business location for transaction of business and record maintenance?

_____Yes _____No Location_____

4. Do you maintain student records on computer?

_____Yes _____No

Type of System:_____

Signature:_____ Date: _____

Name: _____ Position: _____

Rev. 8/1/94

AUTHORITY NOTE: Promulgated in accordance with Act 428 of the 1989 Regular Legislative Session and R.S. 22:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 16:855 (October 1990), amended LR 17:789 (August 1991), LR 20:1391 (December 1994).

Chapter 9. Rule Number 12—Transmission of Forms and Documents

§901. Transmission of Forms and Documents Filed with the Department of Insurance

A. All forms, documents, applications, filings, financial reports, and any and all other forms and types of documents required by law or voluntarily filed with the Commissioner of Insurance by any company regulated by the Office of the Commissioner shall be filed by depositing the same in the United States mail, postage prepaid, and/or electronic transmission. Payment of fees, including license fees, and premium taxes shall be exempt from this rule.

B. No document of any sort or kind described in §901.A will be accepted or received by the personnel of the department as filed with the department unless the same is transmitted to the department via the United States mail and/or electronic transmission.

C. Upon receipt of such documents mailed to the department, the employees of the department charged with the duty of receiving the same shall cause the envelope in which the document was mailed to the department to be attached to the document received in such a way that it shall remain permanently attached to the same, and no employee of the department may remove said envelope for any reason, except as provided for by law.

D. Transmission of documents by facsimile machine, private courier service, or hand delivery is permissible as long as the originals are mailed in the United States Postal Service and received by the Department of Insurance on or before the twentieth day after receipt of the facsimile transmission, private courier delivery, or hand delivery. A document received in accordance with §901 shall be deemed received on the date of the receipt of the original facsimile transmission, private courier delivery, or hand delivery. Any departmental approval shall be indicated on the initial facsimile transmission, private courier delivery, or hand delivery.

E. Notwithstanding §901.A through D, requests for public records shall be in accordance with procedures established for public records requests and record management.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22.2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 17:1210 (December 1991), amended LR 18:620 (June 1992), amended by the Department of Insurance, Office of the Commissioner, LR 29:41 (January 2003).

Chapter 11. Rule Number 1—Rules of Practice and Procedure before the Commissioner of Insurance

§1101. Definitions

A. By reference, all of the definitions set forth and contained in R.S. 49:951 through R.S. 49:966, inclusive, and the Louisiana Insurance Code (Title 22, of the Louisiana Revised Statutes of 1950, as amended) are incorporated herein, and for the purpose of hearings to be held hereunder, the following definitions shall prevail.

Applicant—the applicant shall be the person, persons, firm, company, partnership, association, insurer or corporations, as well as the commissioner or department seeking relief before the Commissioner of Insurance. The term *applicant* may otherwise be styled *petitioner* or *complainant*.

Commissioner—when used herein shall mean the Commissioner of Insurance, or his deputy, examiner or hearing officer appointed by him.

Department—department shall, for all purposes herein, mean the Department of Insurance.

Hearing—any contested case or any formal proceeding before the commissioner brought pursuant to any law of the state of Louisiana or rule or regulation of the commissioner, whether or not the same is adversary in nature.

Respondent—the person, persons, firms, companies, partnerships, associations, insurers, or corporations, including the commissioner and the department against whom any proceeding or application for relief is brought.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1103. Commencement of Hearings

A. All hearings initiated by an applicant other than the commissioner and those initiated by the commissioner for the purpose of promulgating rules or regulations, shall be commenced by filing of a written petition or complaint with the commissioner. Hearings initiated by the commissioner, except for promulgating of a rule or regulation, shall be commenced by the issuance of an order to show cause directed to the respondent, wherein shall be alleged the acts or omissions of acts claimed in violation of the law, or of any of the lawful rules, regulations or orders promulgated by the commissioner thereunder and by authority thereof. Hearings initiated by the commissioner for the purpose of adoption, amendment or repeal of any rule shall be in accordance with the requirements of R.S. 49:953(A)(1). The commissioner will maintain a list of persons who have made requests, in writing, for advance notice of such hearings, and will give notice by certified mail to such persons in accordance with R.S. 49:953(A)(1).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1105. Petitions, Complaints or Orders

A. The applicant desiring, or required by law, to institute a hearing shall prepare and file with the commissioner a petition, complaint or order to show cause setting forth:

1. the name and address of each respondent;

2. a statement, in ordinary and concise language, of the facts upon which the petition, complaint or order to show cause is based, together with supporting evidentiary material including, whenever applicable, particular reference to the statute or statutes, or rules, regulations, and orders that the applicant alleges have been violated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1107. Notice

A. Upon the filing of a petition, order or complaint, or where rules and regulations are proposed for adoption by the commissioner, he shall issue a notice in conformity with the provisions of R.S. 49:955 and R.S. 22:1354.C whenever applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1109. Service of Notice

A. Notice may be served, personally or by certified or registered mail, return receipt requested. Service of orders to show cause by the commissioner shall be made upon any officer of corporate parties at their domicile or principal offices. Reasonable notice shall be construed to mean service of notice at least 20 days prior to the date of the hearing, except where notice is given in connection with a hearing to adopt rules or regulations, in which event the provisions of R.S. 22:1354.C shall govern. Service by mail shall be deemed complete at the date of mailing.

B. In addition to the notice above provided, the commissioner may, in his discretion, require additional notice to be given in such manner as he shall direct.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1111. Proof of Service

A. There shall appear on all documents required to be served an acknowledgment of service or the following certificate.

I hereby certify that I have this day served the foregoing document upon all parties of record in this proceeding (by delivering a copy thereof in person to_____) (by mailing a copy thereof properly addressed, with postage prepaid, to _____). Dated at _____, this ____ day of_____ 19____.

_____
Signature

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1113. Answer or Appearance

A. A respondent may file his answer or other appearance on or before the date fixed for hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1115. Leave to Intervene Necessary

A. Persons, other than the original parties to any proceeding, whose interests are to be directly and immediately affected by the proceeding, shall secure an order from the commissioner, or hearing officer appointed by him, granting leave to intervene before being allowed to participate; provided that the granting of leave to intervene in any matter or proceeding shall not be construed to be a finding or determination of the commissioner or the hearing officer for purposes of court review or appeal.

B. Petitions for leave to intervene must be in writing and must clearly identify the proceeding in which it is sought to intervene. Such petition must set forth the name and address of the petitioner and contain a clear and concise statement of the direct and immediate interest of the petitioner in such proceeding, stating the manner in which such petitioner will be affected by such proceeding, outlining the matters and things relied upon by such petitioner as a basis for his request to intervene in such cause, and if affirmative relief is sought, the petition must contain a clear and concise statement of relief sought and the basis thereof, together with a statement as to the nature and quantity of evidence petitioner will present if such petition is granted.

C. Petitions to intervene and proof of service of copies thereof on all other parties of record shall be filed not less than two days prior to the commencement of the hearing. Thereafter, such petition shall state a substantial reason for such delay. Otherwise, such petition will not be considered. If a petition to intervene shows direct and immediate interest in the subject matter of the proceeding or any part thereof and does not unduly broaden the issues, the commissioner may grant leave to intervene or otherwise appear in the proceeding with respect to the matters set out in the intervening petition, subject to such reasonable conditions as may be prescribed. If it appears during the course of a proceeding that an intervenor has no direct or immediate interest in the proceeding, and that the public interest does not require his participation therein, the commissioner may dismiss him from the proceeding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1117. Docket

A. When a hearing is instituted, it shall be assigned a number and entered with the date of its filing on a separate page of docket provided for such purpose. The department shall establish a separate file for each such docketed case, in which shall be systematically placed all papers, pleadings, documents, transcripts, evidence and exhibits pertaining thereto, and all such items shall have noted thereon the docket number assigned, and the date of filing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1119. Default in Answering or Appearing

A. In the event of the failure of any respondent to answer or otherwise appear within the time allowed, and provided that the foregoing rules as to service have been complied with, the respondent or respondents so failing to answer or otherwise plead or to appear, shall be deemed to be in default, and the allegations of the complaint, petition, or order to show cause, as the case may be, together with the evidence to support the same, shall be entered into the record and may be taken as true and the order of the commissioner entered accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1121. Subpoenas

A. As authorized by R.S. 49:956(5), and R.S. 22:1358.B, subpoenas for appearance and to produce books, papers, documents or exhibits will be issued by the commissioner upon written request of any party.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1123. Prehearing Conference

A. The commissioner or hearing officer may, upon his own motion or upon the motion of any party of record, by giving seven days' prior written notice of the time and place to all parties of record, hold a prehearing conference for the purpose of:

1. formulating or simplifying the issues;

2. obtaining admissions of fact and of documents which will avoid unnecessary proof;

3. arranging for the exchange of proposed exhibits or prepared expert testimony;

4. limiting the number of witnesses; and

5. considering such other matters which may expedite orderly conduct and disposition of the proceedings or settlement thereof.

B. The action taken at such conference and all the agreements, admissions or stipulations made thereat by the parties concerned shall be made a part of the record and shall be approved by such parties. When so approved, such action will control the course of subsequent proceedings, unless otherwise stipulated by all parties of record with the consent of the commissioner or hearing officer.

C. In any proceeding the commissioner or hearing officer may, in his discretion, call all parties together for a conference prior to the taking of testimony, or may recess the hearing for such conference. The commissioner or hearing officer shall state on the record the results of such conference.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1125. Hearing

A. At the date, time and place of the hearing as having been set down by the commissioner, and in accordance with the notice given, the commissioner or hearing officer shall hear all matters presented. All issues and matters enumerated and described in the pleadings given shall be presented by the applicant. The commissioner may be represented by any member of his staff and all other parties may be represented, personally or by counsel, provided that such counsel be duly authorized to practice law in the state of Louisiana or is otherwise associated at the hearing with one or more attorneys authorized to practice law in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1127. Order of Procedure at Hearing

A. As nearly as may be, hearings shall be conducted in accordance with the following order of procedure.

1. The commissioner shall announce that the hearing is convened upon the call of the docket number and title of the matter and case to be heard, and thereupon the commissioner shall direct the reading into the record of the petition or formal notice given, together with appearances made by any respondent or respondents, and shall note, for the record, all subpoenas issued and the returns thereon and all appearances of record, including counsel of record.

2. The applicant shall thereupon proceed to present his evidence. Witnesses may be cross-examined by the respondent or respondents. All exhibits offered by and on behalf of the applicant shall be marked by letters of the alphabet beginning with "A".

3. The respondent or respondents shall, in the order of answers or appearances made, be heard in the same manner as the applicant's evidence, witnesses and exhibits have been heard and presented. Each respondent's exhibits shall be marked separately so as to identify the respective respondent and numbered commencing with the number "1".

4. Opening statements may be permitted and rebuttal evidence presented at the discretion and order of the commissioner.

5. Closing statements, at the conclusion of the presentation of evidence, may be made by the applicant and by the respondent. The time for oral argument may be limited by the commissioner.

6. The commissioner or hearing officer may adjourn any hearing pursuant to R.S. 22:1356.

7. After all proceedings have been concluded, the commissioner shall dismiss and excuse all witnesses and declare the hearing closed. Any party who may wish or desire to tender written briefs of law to the commissioner may do so within reasonable time limits fixed by the commissioner or hearing officer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1129. Witnesses to be Sworn

A. All persons testifying at any hearing before the commissioner shall stand and be administered the following oath by the commissioner:

> "Do you swear or affirm to tell the truth, the whole truth and nothing but the truth in this matter now being heard so help you God."

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1131. Rules of Pleading and Evidence

A. Formal rules of pleading or evidence need not be observed at the hearing.

B. On his own motion the commissioner or hearing officer may, and on request of a party he shall, order that the witnesses, other than parties, be excluded from the hearing or from a place where they can see or hear the proceedings, and refrain from discussing the facts of the case with anyone other than counsel in the case. In the interest of justice, he may exempt any witness from his order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1133. Attorneys

A. The filing of an answer or other appearance by an attorney constitutes his appearance for the party for whom the pleading is filed. The commissioner shall be notified in writing of his withdrawal from any hearing. Any person appearing before the commissioner at a hearing in a representative capacity shall be precluded from examining or cross-examining any witness unless such person shall be an attorney licensed to practice law in the state of Louisiana, or a non-resident attorney associated with a Louisiana attorney qualified to practice law in the state of Louisiana. This rule shall not be construed to prohibit any person from representing himself in any hearing before the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1135. Stenographic Record of Hearing

A. At the expense of and at the written request made not less than four days prior to the date set for the hearing by any person affected by the hearing the Commissioner of Insurance or the person designated by him to hold the hearing shall cause a full stenographic record of the proceedings to be made by a competent stenographic reporter, and if transcribed, such records shall be made a part of the record of the Commissioner of Insurance of the hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1137. Depositions

A. In all contested cases coming before the commissioner, the taking of depositions and discovery shall be available to the parties in accordance with the provisions of R.S. 49:956 and C.C.P. Articles 1421 through 1515, inclusive.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1139. Decision, Findings of Fact and Conclusions of Law and Order

A. The commissioner shall within 30 days after termination of hearing, make and enter his written order thereon containing Findings of Fact and Conclusions of Law. Such decision and order shall be filed in his office and will, without further action, become the decision and order of the commissioner. Forthwith upon entry and filing, the department shall, subject to §1139.D, send a copy by prepaid mail to each party, or their attorneys of record, to whom notice of the hearing was given or required to be given.

B. The order shall contain:

1. a concise statement of the action taken;

2. the effective date of such action;

3. a designation of the provisions of the Louisiana Insurance Code pursuant to which the action is taken;

4. a concise statement of the findings of the Commissioner of Insurance in support of the action.

C. An order on hearing may confirm, modify or nullify actions taken under an existing order, or may constitute the taking of any new action coming within the scope of the notice of such hearing.

D. If notice of such hearing was given by publication as provided for in R.S. 22:1354, the Commissioner of Insurance may publish the order on hearing once each week for four successive weeks in the same newspapers in which such notice was published, the first such publication to be made as soon as possible after the date of the order. Such publication of the order on hearing shall be in lieu of the requirement that a copy of such order be given to each person as provided in §1139.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1141. Rehearings

A. The commissioner may, upon motion therefor made within 10 days after service of a decision and order, order a rehearing upon such terms and conditions as he may deem just and proper if a petition for judicial review of the decision and order has not been filed. Such motion shall not be granted except upon a showing that there is additional evidence which is material and necessary and reasonably calculated to change the decision; that the decision or order is clearly contrary to the law and the evidence; that there is a showing that issues not previously considered ought to be examined in order to properly dispose of the matter; or there is other good ground for further consideration of the issues and the evidence in the public interest. The motion shall be supported by an affidavit of the moving party or his counsel showing with particularity the materiality and necessity of the additional evidence or other grounds above recited and the reason why such evidence was not introduced at the hearing or other grounds above recited. Upon rehearing, the commissioner may modify his decision and order as the additional evidence or other grounds relied upon may warrant. The commissioner shall grant or deny a motion for rehearing within 10 days from his receipt of same.

B. The petition of a party for rehearing, reconsideration, or review, and the order of the commissioner granting it, shall set forth the grounds which justify such action. Nothing in §1141 shall prevent rehearing, reopening or reconsideration of a matter of the commissioner in accordance with other statutory provisions applicable to such agency, or at any time, on the ground of fraud practiced by the prevailing party or of procurement of the order by perjured testimony or fictitious evidence. On reconsideration, reopening, or rehearing, the matter may be heard by the commissioner or it may be referred to a subordinate deciding officer. The hearing shall be confined to those grounds upon which the reconsideration, reopening, or rehearing was ordered. If an application for rehearing shall be timely filed, the period within which judicial review, under the applicable statute must be sought, shall run from the final disposition of such application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1143. Appeals to the District Court

A. Appeals to the Nineteenth Judicial District Court from decisions of the commissioner are governed by R.S. 49:963 and R.S. 49:964 and R.S. 22:1363-1365 inclusive.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1145. Transcript in Case on Appeal

A. In the case of an appeal to the district court as provided in §1143, the party appealing shall secure and file a complete transcript of the testimony and all other evidence offered at the hearing, which transcript must be verified by the oath of the reporter who took the testimony as true and correct transcript of the testimony and all other evidence in the case. The compensation of the reporter for making the transcript of the testimony shall be borne by the party prosecuting such appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1147. Amendment of Rules

A. These rules may be amended and any such amendments shall become effective as provided by R.S. 49:953 and R.S. 49:954.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1149. Exclusions

A. Nothing in these rules shall be construed to prohibit the commissioner from holding informal proceedings, hearings or conferences for the purpose of aiding the commissioner in ascertaining and determining facts necessary for the performance of his duties. Any person believing himself aggrieved by a determination made by the commissioner following an informal proceeding, hearing or conference, and who is otherwise entitled thereto, may, upon filing a petition or complaint pursuant to §1105 of these rules, obtain a full hearing or review upon the merits, which matter shall be heard and tried de novo.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1151. Declaratory Orders and Rulings, Judicial Review

A. A person entitled to the same is granted the right to seek from the commissioner a declaratory order or ruling on the applicability of any statute or rule or order of the commissioner. Requests for such order or rule shall be in writing and shall disclose the necessity for such declaratory order or rule. The commissioner shall issue his order or rule within 30 days from his receipt of the request for the same. Pending the issuance of the commissioner's order, all further proceedings shall be stayed.

B. The validity or applicability of a rule may be determined by an action for declaratory judgment in the 19th Judicial District Court as provided in R.S. 49:962, R.S. 49:963 and R.S. 49:964.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1153. Forms

A. No particular forms are prescribed, and formal rules of procedure are not required. All requests by any person for any action to be taken by the commissioner, including requests for repeal of the rules, shall be in writing. Whenever such request is for the promulgation or amendment of a rule, it shall be accompanied by a final draft of the proposed rule or amendment to a rule. Such requests may be transmitted through the mail or delivered in person to the commissioner or any member of his staff at his office in Baton Rouge, Louisiana.

B. All pleadings which are filed by or on behalf of any person shall be in writing and the person filing the same shall certify that a copy of the same has been furnished to all parties to the hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

§1155. Supersedes All Prior Rules

A. This Rule 1 supersedes any rules of procedure before the Commissioner of Insurance of the State of Louisiana previously promulgated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:1351-1367.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, February 12, 1973.

Chapter 13. Rule Number 3—Advertisements of Accident and Sickness Insurance

§1301. Purpose

A. The purpose of these rules is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of accident and sickness insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1303. Applicability

A. These rules shall apply to any accident and sickness insurance *advertisement*, as that term is hereinafter defined, intended for presentation, distribution or dissemination in this state when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, or solicitor as those terms are defined in the Insurance Code of this state and these rules.

B. Every insurer shall establish, and at all times, maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer whose policies are so advertised.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1305. Definitions

An Advertisement—for the purpose of these rules shall include:

1. printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays; and

2. descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, and form letters; and

3. prepared sales talks, presentations and material for use by agents, brokers and solicitors.

Exception—for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

Insurer—for the purpose of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity which is defined as an *insuree* in the *Insurance Code* of this state and is engaged in the advertisement of a policy as *policy* is herein defined.

Limitation—for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

Policy—for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life, and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.

Reduction—for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1307. Method of Disclosure of Required Information

A. All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1309. Form and Content of Advertisements

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1311. Advertisements of Benefits Payable, Losses Covered or Premiums Payable

A. Deceptive Words, Phrases or Illustrations Prohibited

1. No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

2. No advertisement shall contain or use words or phrases such as all, full, complete, comprehensive, unlimited, up to, as high as, this policy will help pay your hospital and surgical bills, this policy will help fill some of the gaps that Medicare and your present insurance leave out, this policy will help to replace your income (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy, or which may lead the policyholder to expect payment of benefits which he is not likely to derive, except in very unusual circumstances.

3. An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that is a benefit, such as, describing a waiting period as a *benefit builder*, or stating *even pre-existing conditions are covered after two years*. Words and phrases used in an advertisement to describe such policy limitations, exceptions, and reductions shall fairly and accurately describe the negative features of such limitations, exceptions, and reductions of the policy offered.

4. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as *extra cash*, *extra income*, *extra pay*, or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

5. No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless such statements of such monthly or weekly benefit amounts are followed immediately by equally prominent statements of the benefit payable on a daily basis; for example, either of the following statements is acceptable: "$1,000.00 a month ($33.33 a day) or $33.33 a day ($1,000.00 a month)". When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

6. No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

7. An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously, in prominent type, state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to. the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY".

8. An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan," or use other similar words or phrases because the cost of advertising. and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

9. An advertisement for a policy specifically designed to augment benefits available under the Federal Medicare Act shall not exaggerate the policy benefits and shall clearly disclose in unmistakable language what Medicare benefits the policy is designed to complement, and what Medicare benefits the policy will not complement. No such advertisement shall use the term *Medicare Supplement*, or similar term, to describe the policy being offered unless the policy provides a benefit for those items that make up the deductible and related coinsurance amounts of Part A and Part B of the Federal Medicare Act.

10. An advertisement that makes a reference to the policy benefits being paid directly to an insured is prohibited unless, in making such a reference, the advertisement includes a statement that the benefits will be paid directly to a hospital or any other provider of health care services if an assignment of the policy benefits has been made.

B. Exceptions, Reductions and Limitations

1. When an advertisement refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

2. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

3. An advertisement shall not use the words *only*, *just*, *merely*, *minimum* or similar words or phrases to describe the applicability of any exceptions and reductions, such as:

> "This policy is subject to the following minimum exceptions and reductions."

C. Pre-Existing Conditions

1. An advertisement which is subject to the requirements of §1309.B shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term *pre-existing condition* without an appropriate definition or description shall not be used.

2. When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase *no medical examination required* and phrases of similar import, but does not prohibit explaining *automatic issue*. If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

3. When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the

pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

a. Do you understand that this policy will not pay benefits during the first _____ year(s) after the issue date for a disease or physical condition which you now have or have had in the past? YES

b. or substantially the following statement:

I understand that the policy applied for will not pay benefits for any loss incurred during the first _____ year(s) after the issue date on account of disease or physical condition which I now have or have had in the past.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1313. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination

A. When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1315. Testimonials or Endorsements by Third Parties

A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisements, including such statement, are subject to all the provisions of these rules.

B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union scale wages required by union rules if the payment is actually for such scale for TV or radio performances. The payment of substantial amounts, directly or indirectly, for travel and entertainment for filming or recording of TV or radio advertisements, remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation.

C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

D. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information, shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1317. Use of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

B. An advertisement shall not represent or imply that claim settlements by the insurer are liberal or generous, or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1319. Identification of Plan or Number of Policies

A. When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

B. When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1321. Disparaging Comparisons and Statements

A. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1323. Jurisdictional Licensing and Status of Insurer

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression, directly or indirectly, that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability or its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States Government.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1325. Identity of Insurer

A. The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all of its advertisements. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which, without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

> NOTE: The above Section does not require disclosure of a policy form number where the advertisement does not relate specifically to a particular policy or benefit, but is general in nature and would be regarded as *Institutional Advertisement* according to custom and usage.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1327. Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1329. Introductory, Initial or Special Offers

A.1. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as *special*, *limited*, or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.

2. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than 10 days and not more than 40 days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitation, of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the *Insurance Code* for group, blanket or franchise insurance. The phrase *any one insurer* includes all the affiliated companies of a group of insurance companies under common management or control.

3. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

4. The phrase *a particular insurance product* in §1329.A.2 means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

C. Special awards, such as a safe drivers' award shall not be used in connection with advertisements of accident or accident and sickness insurance.

D. An advertisement using terminology to indicate that a particular form of coverage is unlike any other form of coverage presently in existence is prohibited if similar plans and offers are available.

E.1. An advertisement of an individual policy which provides an application or enrollment form shall contain a policy summary setting out the essential features of the policy that will be issued upon acceptance of an application by the insurer. Essential features must include language describing:

a. benefits;

b. renewability of policy;

c. right of company to change premium;

d. liability of company for pre-existing conditions;

e. waiting periods for which no benefits are payable;

f. reduction (if any) of benefits;

g. exclusions.

2. The policy summary shall be prominently displayed and readily distinguishable from all other portions of the advertisement. The policy summary shall explain the essential features of the policy in simple, concise and readily understandable language, as in the following example:

POLICY SUMMARY (or other descriptive title)
A. This policy provides $16.27 daily hospital benefits.
B. This policy is guaranteed renewable to age 65.
C. The insurance company can change the premium.
D. Pre-existing conditions are not covered for the first two years.
E. Benefits are payable from the first day of accidents and the eighth day of sickness.
F. Benefits are reduced at age 65.
G. This policy does not cover mental illness, alcoholism or drug addiction.
H. (Other significant policy provisions.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1331. Statements about an Insurer

A. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1333. Enforcement Procedures

A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance. Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of these rules must file with this department with its annual statement a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the insurance laws of this state, as implemented and interpreted by these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1335. Severability Provision

A. If any Section or portion of a Section of these rules, or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

§1337. Effective Date

A. This rule shall become effective November 1, 1973.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, November 1, 1973.

Chapter 15. Rule Number 5—Unfair Trade Practices

§1501. Purpose

A. The purpose of this rule is to accomplish a uniform application of Louisiana R.S. 22:1214.A(4), (8), and (9). It is intended to clarify those provisions of the Unfair Trade Practices Part of the *Louisiana Insurance Code*. (Title 22, Louisiana Revised Statute of 1950 as amended).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 6:283 (June 1980).

§1503. Applicability

A. These provisions shall be applicable to any persons directly or indirectly involved in the solicitation, negotiation and service of insurance contracts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 6:283 (June 1980).

§1505. Definitions

A. When used in this rule, the following words or terms have the meaning described in §1505.

Confidential Information—information obtained by means of a confidential or fiduciary relationship and the existence of such relationship precludes the party in whom trust and confidence is placed from participating in profit or advantages resulting from the dealing as the parties to the relation. Specifically, information given a mortgagee pertaining to expiration date of insurance contracts and rating and coverages information is confidential information.

Person—any individual, company, insurer, association, organization, reciprocal or interinsurance exchange, partnership, business, trust or corporation.

Unfair Competition—the improper use of confidential information for competitive advantages.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 6:283 (June 1980).

§1507. Rule

A. It shall be an unfair trade practice for any person to engage in unfair competition by directly or indirectly using confidential information in the solicitation, negotiation, and service of insurance contracts, unless the disclosure of such information is authorized by the insured.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 6:283 (June 1980).

Chapter 17. Rule Number 6—Vehicle Mechanical Breakdown Insurer

§1701. Purpose

A. The purpose of this rule is to adopt provisions and uniform guidelines for their interpretation as authorized specifically by Act 520 of the 1978 Regular Session of the Louisiana Legislature. It is designed to facilitate and implement the provisions of that Act. It is intended to supplement and not alter in any manner certain provisions of the Act. A further purpose is to establish reasonable guidelines pertaining to reserves and the adequacy of those reserves, to maintain solvency as respects vehicle mechanical breakdown insurers doing business in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1703. Applicability

A. Those provisions shall be applicable to any and all entities which may be defined as a *vehicle mechanical breakdown insuree*, under the provisions of Act 520 of the 1978 Regular Session of the Louisiana Legislature. The term shall include any person or other entity which receives any fee or compensation for administration of a mechanical breakdown program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1705. Definitions

A. When used in this rule, the following words or term have the meaning described in §1705.

Commissioner—the Commissioner of Insurance for the state of Louisiana.

Insurer—any property or casualty insurer duly authorized to transact vehicle physical damage insurance in this state under provisions of the *Louisiana Insurance Code* other than Sections 1800 through 1810.

Vehicle Mechanical Breakdown Insurance Policy—any contract, agreement, or other instrument whereby a person other than the owner, seller, or lessor of a vehicle assumes the risk of and/or the expense portion thereof for the mechanical breakdown or mechanical failure of a motor vehicle and shall include those agreements commonly known as vehicle service agreements or extended warranty agreements.

Vehicle Mechanical Breakdown Insurer—any person or organization, whether domestic, foreign or alien that issues or attempts to issue vehicle mechanical breakdown policies as defined herein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1707. Qualifications

A. Evidence must be submitted to the Commissioner of Insurance that the applicant is a solvent corporation, incorporated under the laws of Louisiana, or another state, district, territory or possession of the United States of America. That evidence must be submitted as required by Form VMB-1 furnished by the Commissioner of Insurance and must be to his satisfaction.

B. The 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. That information shall be submitted on form VMB-2 which is furnished by the commissioner.

C. The applicant shall make the deposit required by Louisiana R.S. 22:1804. Should the applicant furnish a surety bond, it shall be in the style of Form VMB-4 which is furnished by the commissioner. Such bond must be written by a company that is lawfully authorized to transact surety insurance in this state.

D. The applicant must complete and file form VMB-5, "Consent to Service and Appointment of Registered, Resident Agent" with the commissioner. The commissioner shall provide the applicable forms.

E. No applicant shall be licensed unless it maintains reserves as required by §1709 of this rule.

F. Upon meeting these requirements to the satisfaction of the commissioner, a certificate of authority to do business in this state will be issued.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1709. Reserves

A. Reserving

1. The reserve to be maintained on policies issued covering new vehicles shall be one which generates an unearned premium reserve of not less than the unearned premium reserve which is generated by applying the reverse sum of the digits earnings method to each policy issued covering a new vehicle.

2. The reserve to be maintained on policies issued on used vehicles shall be a reserve of not less than the unearned premium reserve which is generated when the straight line or pro-rated earnings method is applied to each policy issued on a used vehicle.

B. Premium Definition. In items §1709.A.1 and 2 the unearned premium reserves generated shall be those which are generated when the earnings method is applied to the net premium (after commissions to agents) received by the vehicle mechanical breakdown insurer.

C. Reinsurance

1. Should any vehicle mechanical breakdown insurer reinsure all or a portion of its risks through another insurance company, the sum of the reserves maintained by said reinsurance company (for the risk in question) and the reserves maintained by the vehicle mechanical breakdown insurer shall equal not less than the reserve required in §1709.A. Further, such reinsurance shall be admissible toward achieving required reserves only when said reinsurance is with a company or companies that are approved to do business in this state either as a domestic, admitted, or surplus lines insurer.

2. The commissioner shall have the right to examine any reinsurance documents or agreements that may be made between vehicle mechanical breakdown insurers and any such approved company and shall have the power to secure such financial information as he deems necessary from said approved reinsurer.

D. At such time as authority is requested to conduct the business of vehicle mechanical breakdown insurer, the applicant shall fully disclose the reserving method used or to be used by the vehicle mechanical breakdown insurer and shall also disclose any reinsurance agreements which are in existence. Further, if at any time during the conduct of business the mechanical breakdown insurer changes its method of reserving or alters its reinsurance arrangements, if any, written notice shall be given to the Insurance Commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1711. Reports

A. Each vehicle mechanical breakdown insurer shall, on or before the fifteenth day of March of each year, submit to the commissioner a report signed by the president and secretary which shall certify the premiums received by said insurer for the proceeding year. That report shall be audited by a certified public accountant and shall be attested to by him. In conjunction with, and to be submitted at the same time, a complete audited financial statement on the mechanical breakdown insurer. Such audited financial statement shall fully disclose the reserving method used and any reinsurance arrangements in force. Additionally, the audited reports shall contain the following:

1. auditor's report;

2. balance sheet;

3. statement of income and retained earnings;

4. statement of shareholder's equity;

5. statement of changes in financial position;

6. notes to financial statements, which disclose all significant accounting practices.

B. The accounting method used shall not allow for the deferring of acquisition costs, but shall recognize those costs in the period in which they were incurred.

C. The audited statement required shall cover the operations of the mechanical breakdown insurer only. A statement of a holding company, or other parent company, which includes in it the operations of the mechanical breakdown insurer shall not be acceptable to the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1713. Penalty for Non-Compliance

A. Non-compliance with the provisions of this rule may result in the suspension, revocation or non-renewal of the Certificate of Authority issued by the Commissioner of Insurance pursuant to the provisions of Act 520 of the 1978 Regular Session of the Louisiana Legislature.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

§1715. Severability

A. If any of the provisions of this rule are held invalid, such invalidity shall not effect other provisions which can be given effect without the invalid item and to this end provisions of this rule are hereby declared severed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and Act 520 of the 1978 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 7:340 (July 1981).

Chapter 19. Rule Number 7—Legal Expense Insurers

§1901. Purpose

A. The purpose of these rules is to adopt uniform guidelines and requirements applicable to legal expense insurers that do business in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1903. Applicability

A. The rules shall apply to all legal expense insurers as defined herein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1905. Definitions

A. When used in these rules, the following words or terms have the meaning described in §1905.

Agent—an individual who is a resident of this state; or whose principal office is in this state, or a partnership the members of which are residents of this state or have their principal office in this state, or a corporation having, by its charter, the power to act as an insurance agent and whose principal office is in this state, and whose officers and principal stockholders are residents of this state, authorized, in writing, by an insurer lawfully authorized to transact business in this state, to act as its representative with authority to solicit, negotiate and effect contracts of insurance in its behalf, who or which has an office in this state in which is kept a record of the contracts of insurance signed, countersigned or issued by them.

Commissioner—the Commissioner of Insurance for the State of Louisiana.

Department—the Department of Insurance for the State of Louisiana.

Legal Expense Insurer—any person who accepts a pre-payment 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 reimbursement or payment for legal services at such time in the future that such services may be appropriate or necessary.

Person—an individual, insurers, association, organization, partnership, business, trust or other legal entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1907. Exemptions

A. The following activities are exempted from the provisions of these rules and they shall not be applicable to persons engaged in those capacities:

1. retainer contracts between attorney(s) and client(s);

2. lawyer referral service authorized by the Louisiana Bar;

3. furnishing of legal assistance by labor unions or other employee organizations to their members relating to employment;

4. furnishing of legal assistance to members by a church, cooperation, educational institution, credit union or organization of employees, where the above contract directly with an attorney or firm of attorneys for legal services;

5. employee benefit plans to the extent state laws are superseded by 29 USC 1144, provided evidence of exemption from state law is provided to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1909. Qualifications as Insurer Required

A. Any person who accepts a pre-payment 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 reimbursement or payment for legal services at such time in the future as such services may be appropriate or necessary must meet the requirements of the *Louisiana Insurance Code* by becoming qualified as an insurer which is authorized to write fidelity and surety coverage. (See "Exemptions" under §1907 of this rule.) Persons offering these services shall qualify as a mutual, stock, reciprocal or Lloyds' plan insurer as defined in Title 22, Louisiana Revised Statutes of 1950, as amended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1911. Licensing of Agents Required

A. The legal expense insurer, as defined herein, shall not contract with, or employ, agents that are not properly licensed under the provisions of Title 22, Louisiana Revised Statutes of 1950, as amended, to solicit, negotiate or issue contracts of insurance that afford legal expense coverage. All of the provisions of law applicable to insurance agents, other than life, health, and accident agents, shall apply to those agents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1913. Compliance Required

A. Legal expense insurers that have previously done business in this state as an individual corporation, partnership, or other entity shall, within 60 days following final promulgation of these rules, show that they are in compliance with them and applicable provisions of law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1915. Penalty for Non-Compliance

A. Any legal expense insurer, as defined herein, and that is not subject to the "Exemptions" in §1907 of these rules and who does not hold a current and valid certificate of authority to do business in this state is in violation of R.S. 22:7(A) and the commissioner shall take the necessary steps to enforce those provisions of law. Further, any person who solicits, negotiates, or issues a contract of insurance that affords legal expense insurance coverage as an agent of a legal expense insurer and who does not hold a proper and valid license as an agent shall be subject to the provisions of R.S. 22:1175 and the commissioner shall take the necessary steps to enforce these provisions of the law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

§1917. Severability

A. If any of the provisions of these rules is held invalid, such invalidity shall not affect other provisions which can be given effect without the invalid item, and to this end, the provisions of these rules are hereby declared severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 8:235 (May 1982).

Chapter 21. Rule Number 8—A New Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities

§2100. Authority

A. This rule is promulgated by the Commissioner of Insurance pursuant to R.S. 22:163 of the *Insurance Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:2281 (December 1998).

§2101. Purpose

A. The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table "a," the 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, and the 1994 Group Annuity Reserving (1994 GAR) Table.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998).

§2103. Definitions

1983 GAM Table (as used in this rule)—that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.

1983 Table 'a' (as used in this rule)—that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners.

1994 GAR Table (as used in this rule)—that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force. The 1994 GAR Table is included in the report on pages 865-919 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

Annuity 2000 Mortality Table (as used in this rule)—that mortality table developed by the Society of Actuaries Committee on Life Insurance Research. The Annuity 2000 Table is included in the report on pages 211-249 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998).

§2105. Individual Annuity for Pure Endowment Contracts

A. Except as provided in Subsections B and C of this Section, the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after September 7, 1979.

B. Except as provided in Subsection C of this Section, either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987.

C. Except as provided in Subsection D of this Section, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1999.

D. The 1983 Table "a" without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1, 1999, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

1. settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

2. settlements involving similar actions such as worker's compensation claims; or

3. settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998).

§2107. Group Annuity or Pure Endowment Contracts

A. Except as provided in Subsections B and C of this Section, the 1983 GAM Table, the 1983 Table "a" and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for an annuity or pure endowment purchased on or after September 7, 1979 under a group annuity or pure endowment contract.

B. Except as provided in Subsection C of this Section, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987 under a group annuity or pure endowment contract.

C. The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1999 under a group annuity or pure endowment contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998).

§2108. Application of the 1994 GAR Table

A. In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994}s and AA_xs are as specified in the 1994 GAR Table.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:2281 (December 1998).

§2109. Separability

A. If any provision of this rule or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998).

§2111. Effective Date

A. The effective date of this rule is January 1, 1999.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:1089 (November 1985), amended LR 24:2281 (December 1998).

Chapter 23. Rule 13—Special Assessment to Pay the Cost of Investigation, Enforcement, and Prosecution of Insurance Fraud

Editor's Note: Refer to Act No. 373 of the 2004 Regular Legislative Session.

§2301. Purposes

A. The purpose of this rule is to implement the provisions of R.S. 40:1428 by assessing a fee on insurers to pay the cost of investigation, enforcement, and prosecution of insurance fraud in this state as more fully described in

R.S. 40:1421-1429 and this rule. This rule shall be effective February 20, 2000.

B. The fees collected shall be used solely for the purposes of Subpart B of Part III of Chapter 6 of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1421 through 1429, entitled "Insurance Fraud Investigation Unit".

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 40:1428.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:323 (February 2000).

§2303. Fee Assessment

A. As authorized by R.S. 40:1428, and subject to the limitations provided therein and in this rule, there is hereby assessed an annual fee not to exceed 0.000375 multiplied times the direct premiums received by each insurer licensed by the Department of Insurance to conduct business in this state.

B. The fee shall be assessed for that portion of the 1999-2000 fiscal year, ending June 30, 2000, which follows the effective date of this rule, and on July 1, 2000, and each fiscal year thereafter, and shall be based on premiums received in the previous calendar year. The Commissioner of Insurance will notify insurers in writing of the fee assessment owed each fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 40:1428.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:323 (February 2000).

§2305. Limitations on the Fee Assessment

A. The fee shall not be assessed on premiums received on life insurance policies, annuities, credit insurance, reinsurance contracts, reinsurance agreements, or reinsurance claims transactions. The fee shall not be assessed on fifty percent of the premiums received on health and accident insurance policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 40:1428.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:323 (February 2000).

§2307. Allocation of the Fee Assessment

A. The fees shall be allocated as follows.

1. Seventy-five percent of the fees collected shall be allocated to the Insurance Fraud Investigation Unit within the Office of State Police.

2. Fifteen percent of the fees collected shall be allocated to the Department of Justice to be used solely for the Insurance Fraud Support Unit.

3. Ten percent of the fees collected shall be allocated to the Department of Insurance to be used solely for the Section of Insurance Fraud.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 40:1428.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:323 (February 2000).

§2309. Payment of the Fee Assessment

A. The fee established in R.S. 40:1428 and in this rule shall be paid to the Commissioner of Insurance as required by R.S. 40:1428(B).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 40:1428.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:323 (February 2000).

§2311. Sunset

A. This rule shall be null, void, and unenforceable on July 1, 2004 in accordance with the sunset provision of R.S. 40:1429, unless legislative authorization for this rule is reenacted prior to July 1, 2004. If such legislation authorization is reenacted prior to July 1, 2004, then this rule shall continue in full force in effect without need for a reenactment, amendment, or re-promulgation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, R.S. 40:1428 and R.S. 40:1429.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:323 (February 2000).

Chapter 25. Rule 14—Records Management

§2501. Records Management; General

A. 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 that has reasonable safeguards against erasure or alteration, including the use of programs, methods, procedures and/or services that provide secured, portable document formats and digital signatures, and for which the Department of Insurance has obtained the necessary license(s) and/or authorities to insure reasonable safeguards against erasure or alteration.

AUTHORITY NOTE: R.S. 49:950 et seq.; R.S. 44:1 et seq., R.S. 22:1 et seq.; R.S. 22:2.1.A; R.S. 14:67; R.S. 14:132; and R.S. 9:2601 et seq.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 29:42 (January 2003).

Title 37
INSURANCE
Part XIII. Regulations

Chapter 1. Regulation 31—Holding Company

§101. Purpose

A. The purpose of these regulations is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of Act 794 of the 1991 Regular Legislative Session to be comprised of R.S. 22:1001-1014 of the *Insurance Code*, hereinafter referred to as "the Act." The information called for by these regulations is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§103. Severability Clause

A. If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are normally used.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§105. Definitions

Executive Officer—chief executive officer, chief operation officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

Foreign Insurer—shall include an alien insurer except where clearly noted otherwise.

Ultimate Controlling Person—that person who is not controlled by any other person.

1. Unless the context otherwise requires, other terms found in these regulations and in §1002 of the Act are used as defined in the said §1002. Other nomenclature or terminology is according to the Insurance Code, or industry usage if not defined by the Code.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§107. Subsidiaries of Domestic Insurers

A. The authority to invest in subsidiaries under §1003.B of the Act is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the Insurance Code.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§109. Acquisition of Control—Statement Filing

A. A person required to file a statement pursuant to §1004 of the Act shall furnish the required information on Form A, hereby made a part of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§111. Amendments to Form A

A. The applicant shall promptly advise the commissioner of any changes in the information so furnished on Form A arising subsequent to the date upon which such information was furnished but prior to the commissioner's disposition of the application.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§113. Acquisition of Section 1004.A(l)(2) Insurers

A. If the person being acquired is deemed to be a domestic insurer solely because of the provisions of §1004.A(l)(2)of the Act, the name of the domestic insurer on the cover page should be indicated as follows:

1. "ABC Insurance Company, a subsidiary of XYZ Holding Company".

B. Where a §1004.A(l)(2)insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§115. Annual Registration of Insurers—Statement Filing

A. An insurer required to file an annual registration statement pursuant of §1005 of the Act shall furnish the required information on Form B, hereby made a part of these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§117. Summary of Registration—Statement Filing

A. An insurer required to file an annual registration statement pursuant to §1005 of the Act is also required to furnish information required on Form C, hereby made a part of these regulations. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the commissioner of that state.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§119. Amendments to Form B

A. An amendment to Form B shall be filed within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement.

B. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page "Amendment Number (insert number) to Form B for (insert year)" and shall indicate the date of the change and not the date of the original filings.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§121. Alternative and Consolidated Registrations

A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under §1005(I)of the Act. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system, even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

1. the statement or report contains substantially similar information required to be furnished on Form B; and

2. the filing insurer is the principal insurance company in the insurance holding company system.

B. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact, and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurer holding company system.

C. With the prior approval of the commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under §121.A.

D. Any insurer may take advantage of the provisions of §1005(H) or 1005(I) of the Act without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§123. Disclaimers and Termination of Registration

A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

1. the number of authorized, issued, and outstanding voting securities of the subject;

2. with respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

3. all material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

4. a statement explaining why such person should not be considered to control the subject.

B. A request for termination of registration shall be deemed to have been granted unless the commissioner, within 30 days after he receives the request, notifies the registrant otherwise.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§125. Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

1. the amount of the proposed dividend;

2. the date established for payment of the dividend;

3. a statement as to whether the dividend is to be in cash or other property, and if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for evaluation;

4. a copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

a. the amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurers own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

b. surplus as regards policyholders (total capital and surplus) as of the thirty-first day of December next preceding;

c. if the insurer is a life insurer, the net gain from operation for the 12-month period ending the thirty-first day of December next preceding;

d. if the insurer is not a life insurer, the net income less realized capitalized gains for the 12-month period ending the thirty-first day of December next preceding and the two preceding 12-month periods; and

e. if the insurer is not a life insurer, the dividends paid to stockholders, excluding distributions of the insurers own securities in the preceding two calendar years;

5. a balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and

6. a brief statement as to the effect of the proposed dividend upon the insurers surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

B. Subject to Subsection (b) of Section 1005E of the Act, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within 15 business days following the declaration thereof, including the same information required by Subsections (a)(4) (i)-(v).

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§127. Adequacy of Surplus

A. The factors set forth in §1006(C) of the Act are not intended to be an exhaustive list. In determining the adequacy and the reasonableness of an insurer's surplus no single factor is necessarily controlling. The commissioner will instead consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§129. Transactions Subject to Prior Notice—Notice Filing

A. An insurer required to give notice of a proposed transaction pursuant to §1006(A) of the Act shall furnish the required information on Form D, hereby made a part of these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§131. Instructions for Forms A, B, C, and D

A. General Requirements

1. Forms A, B, C and D are intended to be guides in the preparation of the statements required by §§1004, 1005, and 1006 of this Act. They are not intended to be blank forms which are to be filled in. These statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

2. A complete copy of each statement, including exhibits and all other papers and documents filed as a part thereof, shall be filed with commissioner by U.S. Mail, or as provided by Rule 12 addressed to: Insurance Commissioner of the State of Louisiana, Box 94214, Baton Rouge, LA 70804-9214, Attention: (Chief Examiner). A copy of Form C shall be filed in each state in which an insurer is authorized to do business if the commissioner of that state has notified the insurer of its request, in writing, in which case the insurer has 30 days from receipt of the notice to file such form. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

3. Statements should be prepared on paper 8 1/2" x 11" in size and preferably bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable, and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

B. Forms—Incorporation by Reference, Summaries, and Omissions

1. Information required by an item of Form A, Form B, or Form D may be incorporated by reference in answer or partial answer to any other item. 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 in answer or partial answer to any item of Form A, Form B, or Form D provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the commissioner which were filed within three years need not to be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear, or confusing.

2. Where an item 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 such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with commissioner which was filed within three years and may be qualified in its entirety by such 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 thereto, the dates of execution, or other details, a copy of only one such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

C. Forms—Information Unknown or Unavailable and Extension of Time to Furnish

1. Information required need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because the obtaining thereof would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted, subject to the following conditions:

a. the person filing shall give such information on the subject as it possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and

b. the person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

2. If it is impractical to furnish any required information, document, or report at the time it is required to be filed, there may be filed with the commissioner as a separate document:

a. identifying the information, document, or report in question;

b. stating why the filing thereof at the time required is impractical; and

c. requesting an extension of time for filing the information, document, or report to a specified date. The request for extension shall be deemed granted unless the commissioner within (insert number—probably 60) days after receipt thereof enters an order denying the request.

D. Forms—Additional Information and Exhibits. In addition to the information expressly required to be included in Forms A, B, C or D there shall be added such other material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C or D shall include on the top of the cover page the phrase: "Change Number (insert number) to" and shall indicate the date of the change and not the date of the original filing.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§133. Form A—Acquisition of Control or Merger with a Domestic Insurer

STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____
Name of Domestic Insurer

By

_____
Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

_____
(State of domicile of insurer being acquired)

Dated: _____, 20 _____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should Be Addressed:

_____
_____
_____
_____
_____

ITEM 1. INSURER AND METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Provide a brief but informative description of the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than 1/2 of 1 percent of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings, and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

State the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10 percent or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity, occupation or employment, including position and office held, and the name, principal business, and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, offices, or employment during the last five years, giving the starting and ending dates of each and the name, principal business, and address of any business corporation or other organization in which each such occupation, position, office, or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE, AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source, and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding, or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes, and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge or consolidate it with any person or persons, or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates, or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements, or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss, or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates, or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates, or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates, or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer who is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting materials relating thereto, any proposed employment, consultation, advisory, or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or Regulation Sections 4 and 6.

ITEM 13. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 3 of the Act_____ has caused this application to be duly signed on its behalf in the City of _____ and state of _____ on the _____ day of _____, 20 _____.

(SEAL) _____

Name of Applicant

BY _____

(Name) (Title)

Attest:

_____

(Signature of Officer)

_____

(Title)

CERTIFICATION

The undersigned deposes and says that (s) he has duly executed the attached application dated _____ , 20 _____, for and on behalf of _____that (s)he is the _____ of such

(Name of Applicant) (Title of Officer)

company that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information, and belief.

(Signature)_____

(Type or print name beneath)_____

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§135. Form B—Annual Registration Statement

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the
State of _____

By

_____
(Name of Registrant)

On Behalf of Following Insurance Companies

Name Address

_____
_____
_____
_____

Date: _____, 20 _____

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should Be Addressed:

_____
_____
_____
_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date of which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person within the insurance holding company system unless it has assets valued at or exceeding (insert amount). The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name
(b) Home office address
(c) Principal executive office address
(d) The organizational structure of the person, (i.e., corporation, partnership, individual, trust, etc.)
(e) The principal business of the person
(f) The name and address of any person who holds or owns 10 percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.
(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings, and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her 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.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force; and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
(2) purchases, sales, or exchanges of assets;
(3) transactions not in the ordinary course of business;
(4) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into the ordinary course of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;
(5) all management agreements, service contracts, and all cost-sharing arrangements;
(6) reinsurance agreements;
(7) dividends and other distributions to shareholders;
(8) consolidated tax allocation agreements; and
(9) any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate for a loan made to any member of the insurance holding company system.

Sales, purchases, exchanges, loan or extensions of credit, investments. or guarantees involving the amounts specified in 1005D or less of the Registrant's admitted assets as of the thirty-first day of December next preceding, or such transactions as set forth below, shall not be deemed material.

Sales, purchases, exchanges, loan or extensions of credit, investments or guarantees of less than $25,000 shall not be deemed material even if such transaction would otherwise be deemed material under the provisions of 1005D.Additionally, transactions that fall between $25,000 and $250,000 shall not be deemed material unless such transaction involves .0075 of the admitted assets of the insurer as of the thirty-first day of December next preceding.

The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceeding's by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership, or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENT AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

ITEM 9. FORM C REQUIRED

A Form C, Number Summary of Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of §1005 of the Act, the Registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____, and State of _____on the _____day of _____, 20 _____.

(SEAL)_____
(Name of Registrant)

_____
By (Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of _____; that (s)he is the _____ of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and the facts therein set forth are true to the best of his/her knowledge, information, and belief.

(Signature)_____
(Type or print name beneath)_____

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§137. Form C—Registration Statement Summary

SUMMARY OF REGISTRATION STATEMENT
Filed with the Insurance Department of the
State of_____

By

_____
(Name of Registrant)

On Behalf of the Following Insurance Companies
Name Address

_____
_____
_____
_____

Date: _____, 20_____.
Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of' 10 percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of §1005 of the Act, the Registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____and the State of _____on the _____ day of _____, 20_____.

(SEAL) _____
(Name of Applicant)

By _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached summary of registration statement dated _____ 20_____, for and on behalf of _____(Name of Company); that (s)he is the _____(Title of Officer) of such company and that (s) he is authorized to execute and file such instrument. Deponent further says that (s) he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information, and belief.

(Signature) _____
(Type or print name beneath)_____

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

§139. Form D—Prior Notice of a Transaction

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of _____

By

_____

(Name of Registrant)

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date: _____, 20_____.

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning Statement Should Be Addressed:

_____

_____

_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, (i.e. corporation, partnership, individual, trust, etc.).

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under §1006A(6)(a)(b)(c)(d) or (e)of the Act.

(b) A statement of the transaction.

(c) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OF INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for the evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee, or other arrangement, state the time period during which the investment, guarantee, or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders or, (b) in the case of life insurers, 3 percent of the insurer's admitted assets, each as of the thirty-first day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property, or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders or, with respect to life insurers, 3 percent of the insurer's admitted assets, each as of the thirty-first of December next preceding.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described in §1006A(6)(c)of the Act, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5 percent of the insurer's surplus as regards policyholders, as of the thirty-first day of December next preceding.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS, AND COST-SHARING ARRANGEMENTS

For management and service agreements, furnish:

(a) A brief description of the purpose of the agreement.

(b) A description of the period of time during which the agreement is to be in effect.

(c) A brief description of each party's expenses or costs covered by the agreement.

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of §1006 of the Act, _____ has caused this notice to be duly signed on its behalf in the City of _____and State of _____on the _____day of _____, 20_____.

(SEAL) _____
(Name of Applicant)

By _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, 20_____, for and on behalf of _____; that (s)he is the _____of such company
(Name of Applicant) (Title of Officer)
and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information, and belief.

(Signature)_____
(Type or print name beneath) _____

AUTHORITY NOTE: Promulgated in accordance with R.S.22:1005.D and R.S. 22:1006.A(6)-(9).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 18:274 (March 1992), amended LR 19:501 (April 1993).

Chapter 3. Regulation 32—Group Coordination of Benefits

§301. Purpose and Applicability

A. The purpose of this regulation is to:

1. permit, but not require, plans to include a Coordination of Benefits (COB) provision, unless prohibited by federal law;

2. establish a uniform order of benefit determination under which plans pay claims;

3. provide authority for the orderly transfer of necessary information and funds between plans;

4. reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first;

5. reduce claims payment delays; and

6. require that COB provisions be consistent with this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§303. Definitions

A. As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise.

Allowable Expense—a health care service or expense including deductibles, coinsurance, or copayments that is covered in full or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

a. The following are examples of expenses or services that are not an allowable expense.

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private hospital rooms), is not an allowable expense.

ii. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense.

iii. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

b. The definition of *allowable expense* may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug, or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expenses in its contract to services or expenses that are similar to the services or expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of *allowable expense* shall include similar services or expenses to which COB applies.

c. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

d. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

i. because the covered person does not comply with the plan provisions concerning second surgical opinions or pre-certification of admissions or services; or

ii. because the covered person has a lower benefit because he or she did not use a preferred provider.

e. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were primary when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Claim—a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

a. services (including supplies);

b. payment for all or a portion of the expenses incurred;

c. a combination of Subparagraphs a and b above; or

d. an indemnification.

Claim Determination Period—a period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each plan will pay or provide.

a. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

b. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

Closed Panel Plan—a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Coordination of Benefits—a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent—the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation is the custodial parent.

Hospital Indemnity Benefits—benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan—a form of coverage with which coordination is allowed. The definition of *plan* in the group contract must state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one *plan* and there is no COB among the separate parts of the *plan*.

a. The definition shown in the model COB provision in Appendix A is an example but any definition that satisfies this Subsection may be used.

b. This regulation uses the term *plan*. However, a contract may use "program" or some other term.

c. Plan may include:

i. group insurance contracts and group subscriber contracts;

ii. uninsured arrangements of group or group-type coverage;

iii. group or group-type coverage through closed panel plans;

iv. *group-type contracts*—group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including franchise or blanket coverage. Individually underwritten and issued guaranteed renewable policies are not *group-type* even if purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer;

v. the amount by which group or group-type hospital indemnity benefits exceed $300 per day;

vi. the medical care components of group long-term care contracts, such as skilled nursing care;

vii. the medical benefits coverage in group, group-type, and individual automobile "no fault" and traditional automobile "fault" type contracts; and

viii. Medicare or other governmental benefits, as permitted by law, except as provided in Clause d.ix below. That part of the definition of *plan* may be limited to the hospital, medical, and surgical benefits of the governmental program.

d. Plan shall not include:

i. individual or family insurance contracts;

ii. individual or family subscriber contracts;

iii. individual or family coverage through closed panel plans;

iv. individual or family coverage under other prepayment, group practice, and individual practice plans;

v. group or group-type hospital indemnity benefits of $300 per day or less;

vi. school accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;

vii. benefits provided in group long-term care insurance policies for nonmedical services; for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

viii. Medicare supplement policies;

ix. a state plan under Medicaid; or

x. a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Primary Plan—a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following is true:

a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan—a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

This Plan—in a COB provision, the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from *this plan*. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with similar benefits, and may apply another COB provision to coordinate with other benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§305. Use of Model COB Contract Provision

A. Section 317, Appendix A, contains a model COB provision for use in group contracts. That use is subject to the provisions of §305.B, C, and D and to the provisions of §307.

B. Section 319, Appendix B is a plain language description of the COB process that explains to the covered person how insurers will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (or more) plans will pay for or provide benefits, how the benefit reserve is accrued and how the covered person may use the benefit reserve.

C. The COB provision (§317, Appendix A) and the plain language explanation (§319, Appendix B) do not have to use the specific words and format shown in §317, Appendix A, or §319, Appendix B. Changes may be made to fit the language and style of the rest of the group contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

1. another plan exists and the covered person did not enroll in that plan;

2. a person is or could have been covered under another plan, except with respect to Part B of Medicare; or

3. a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are "always excess" or "always secondary," except in accord with the rules permitted by this regulation.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not

occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan must use the benefit reserve to pay any unpaid allowable expense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§307. Rules for Coordination of Benefits

A. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows.

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

2. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

3. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

4. Order of Benefit Determination. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

a. Nondependent or Dependent. The plan that covers the person other than as a dependent; for example, as an employee, member, subscriber, or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. secondary to the plan covering the person as a dependent; and

ii. primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

b. Child Covered under More Than One Plan

i. The primary plan is the plan of the parent whose birthday is earlier in the year if:

(a). the parents are married;

(b). the parents are not separated (whether or not they ever have been married); or

(c). a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

ii. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

iii. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. Section 307.A.4.c.iii shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

iv. If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(a). the plan of the custodial parent;

(b). the plan of the spouse of the custodial parent;

(c). the plan of the noncustodial parent; and then

(d). the plan of the spouse of the noncustodial parent.

c. Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under §307.A.4.a.

d. Continuation Coverage

i. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary.

ii. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e. Longer or Shorter Length of Coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

i. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended.

ii. The start of a new plan does not include:

(a). a change in the amount of scope of a plan's benefits;

(b). a change in the entity that pays, provides, or administers the plan's benefits; or

(c). a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

f. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§309. Procedure to be Followed by Secondary Plan

A.1. When a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the secondary plan must:

a. determine its obligation, pursuant to its contract;

b. determine whether a benefit reserve has been recorded for the covered person; and

c. determine whether there are any unpaid allowable expenses during that claims determination period.

2. If there is a benefit reserve, the secondary plan shall use the covered person's recorded benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claim determination period the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

1. When the benefits of a plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

2. The requirements of §309.B.1 do not apply if the plan provides only one benefit, or may be altered to suit the coverage provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§311. Notice to Covered Persons

A. A plan shall, in its explanation of benefits provided to covered persons, include the following language:

> "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§313. Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

B.1. A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (noncomplying plan) on the following basis:

a. if the complying plan is the primary plan, it shall pay or provide its benefits first;

b. if the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the. benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

c. if the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

2. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan, and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

3. In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

C. COB Differs from Subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

D. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§315. Effective Date; Existing Contracts

A. This regulation is applicable to every group contract that provides health care benefits and that is issued on or after the effective date of this regulation, which is January 1, 1997.

B. A group contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

1. the next anniversary date or renewal date of the group contract; or

2. the expiration of any applicable collectively bargained contract pursuant to which it was written.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§317. Appendix A—Model COB Contract Provisions Coordination of this Group Contract's Benefits with Other Benefits

A. Coordination

1. This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. *Plan* is defined below.

2. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

3. Definitions

Allowable Expense—a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example, an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses.

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.

ii. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

iii. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.

v. The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

Claim Determination Period—a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

Closed Panel Plan—a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent—a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan—any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

i. *Plan* includes:

(a). group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);

(b). hospital indemnity benefits in excess of $300 per day; medical care components of group long-term care contracts, such as skilled nursing care;

(c). medical benefits under group or individual automobile contracts; and

(d). Medicare or other governmental benefits, as permitted by law.

ii. *Plan* does not include:

(a). individual or family insurance;

(b). closed panel or other individual coverage (except for group-type coverage);

(c). amounts of hospital indemnity insurance of $300 or less per day; school accident type coverage, benefits for nonmedical components of group long-term care policies;

(d). Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

iii. Each contract for coverage under Clause i or ii is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

iv. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

v. When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

B. Order of Benefit Determination Rules

1. When two or more plans pay benefits, the rules for determining the order of payment are as follows.

a. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

b. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception:

i. coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

c. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

d. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

i. Nondependent or Dependent. The plan that covers the person other than as a dependent, (for example, as an employee, member, subscriber, or retiree) is primary, and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

ii. Child Covered under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

(a). the primary plan is the plan of the parent whose birthday is earlier in the year if:

(i). the parents are married;

(ii). the parents are not separated (whether or not they ever have been married); or

(iii). a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

(b). if both parents have the same birthday, the plan that covered either of the parents longer is primary;

(c). if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree;

(d). if the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(i). the plan of the custodial parent;

(ii). the plan of the spouse of the custodial parent;

(iii). the plan of the noncustodial parent; and then

(iv). the plan of the spouse of the noncustodial parent.

iii. Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled §317.B.1.d.ii.(d).(i).

iv. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

v. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber, or retiree longer is primary.

vi. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

C. Effect on the Benefits of This Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

a. determine its obligation to pay or provide benefits under its contract;

b. determine whether a benefit reserve has been recorded for the covered person; and

c. determine whether there are any unpaid allowable expenses during that claims determination period.

2. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

3. If a covered person is enrolled in two or more closed panel plans, and if for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. Right to Receive and Release Needed Information Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Organization responsible for COB administration may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Organization responsible for COB administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give organization responsible for COB administration any facts it needs to apply those rules and determine benefits payable.

E. Facility of Payment. A payment made under another plan may include an amount that should have been paid under this plan. If it does, organization responsible for COB administration may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Organization responsible for COB administration will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. Right of Recovery. If the amount of the payments made by organization responsible for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

§319. Appendix B—Consumer Explanatory Booklet Coordination of Benefits

Important Notice: This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated This is not a complete description of all the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

A. Double Coverage

1. It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

2. When you are covered by more than one group health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

3. Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

B. Primary or Secondary?

1. You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

2. Any plan which does not contain your state's coordination of benefits rules will always be primary.

C. When This Plan Is Primary

1. If you or a family member are covered under another plan in addition to this one, we will be primary when:

a. your own expenses. The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired;

b. your spouse's expenses. The claim is for your spouse, who is covered by Medicare, and you are not both retired;

c. your child's expenses:

i. the claim is for the health care expenses of a child covered by this plan; and

ii. your birthday is earlier in the year than your spouse's. This is known as the "birthday rule"; or

iii. you are not married and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

iv. there is no court decree, but you have custody of the child.

D. Other Situations. We will be primary when any other provisions of state or federal law require us to be.

E. How We Pay Claims When We Are Primary. When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

F. How We Pay Claims When We Are Secondary

1. We will be secondary whenever the rules do not require us to be primary.

2. When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

3. If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) usually have contracts with their providers.

4. We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

5. If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.

6. We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

G. Benefit Reserve

1. When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve.

a. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings.

b. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans.

c. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997).

Chapter 5. Regulation 33—Medicare Supplement Insurance Minimum Standards

§501. Purpose

A. The purpose of this regulation is:

1. to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

2. to facilitate public understanding and comparison of such policies;

3. to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

4. to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999), repromulgated LR 25:1481 (August 1999), LR 29:2434 (November 2003), LR 31:2902 (November 2005).

§502. Applicability and Scope

A. Except as otherwise specifically provided in §§510, 540, 545, 560 and 585, this regulation shall apply to:

1. all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

2. all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to 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 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.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999), repromulgated LR 25:1481 (August 1999), LR 29:2434 (November 2003), LR 31:2902 (November 2005).

§503. Definitions

A. For purpose of this regulation:

Applicant—

a. in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

b. in the case of a group Medicare supplement policy, the proposed certificateholder.

Bankruptcy—when a Medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

Certificate—any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

Certificate Form—the form on which the certificate is delivered or issued for delivery by the issuer.

Continuous Period of Creditable Coverage—the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

Creditable Coverage—

a. with respect to an individual, coverage of the individual provided under any of the following:

i. a group health plan;

ii. health insurance coverage;

iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

v. Chapter 55 of Title 10 United States Code (CHAMPUS);

vi. a medical care program of the Indian Health Service or of tribal organization;

vii. a state health benefits risk pool;

viii. a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

ix. a public health plan as defined in federal regulation; and

x. a health benefit plan under Section 5(e) of the Peace Corps Act [22 United States Code 2504(e)];

b. creditable coverage shall not include one or more, or any combination, of the following:

i. coverage only for accident or disability income insurance, or any combination thereof;

ii. coverage issued as a supplement to liability insurance;

iii. liability insurance, including general liability insurance and automobile liability insurance;

iv. workers compensation or similar insurance;

v. automobile medical payment insurance;

vi. credit-only insurance;

vii. coverage for on-site medical clinics; and

viii. other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

c. creditable coverage shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

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; and

iii. such other similar, limited benefits as are specified in federal regulations;

d. creditable coverage shall not include the following benefits if offered as independent, noncoordinated benefits:

i. coverage only for a specified disease or illness; and

ii. hospital indemnity or other fixed indemnity insurance;

e. creditable coverage shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

i. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

ii. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

iii. similar supplemental coverage provided to coverage under a group health plan.

Employee Welfare Benefit Plan—a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

Insolvency—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:

a. any capital and surplus required by law for its organization; and

b. the total par or stated value of its authorized and issued capital stock;

c. for purposes of this Subsection, 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.

Issuer—insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity authorized to deliver or issue for delivery in this state Medicare supplement policies or certificates.

Medicare—the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Advantage Plan—a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title 42 U.S.C. 1395w-28(b)(1), and includes:

a. coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

b. medical savings account plans coupled with a contribution into a Medicare advantage plan medical savings account; and

c. Medicare advantage private fee-for-service plans.

Medicare Supplement Policy—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. Section 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 reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. *Medicare supplement policy* does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug Plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

Policy Form—the form on which the policy is delivered or issued for delivery by the issuer.

Qualified Actuary—an actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

Secretary—the Secretary of the United States Department of Health and Human Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 43 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999), repromulgated LR 25:1481 (August 1999), amended LR 29:2435 (November 2003), LR 31:2902 (November 2005).

§504. Policy Definitions and Terms

A. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms, which conform to the requirements of this Section.

Accident, Accidental Injury, or Accidental Means—defined to employ "result" language and shall not include words, which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words or description or characterization.

a. The definition shall not be more restrictive than the following.

> NOTE: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

b. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

Benefit Period or *Medicare Benefit Period*—shall not be defined more restrictively than as defined in the Medicare program.

Convalescent Nursing Home, *Extended Care Facility*, or *Skilled Nursing Facility*—shall not be defined more restrictively than as defined in the Medicare program.

Health Care Expenses—for the purposes of §545, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

Hospital—may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations, but not more restrictively than as defined in the Medicare program.

Medicare—shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

Medicare Eligible Expenses—expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician—shall not be defined more restrictively than as defined in the Medicare program.

Sickness—shall not be defined to be more restrictive than the following.

a. Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

b. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999), repromulgated LR 25:1482 (August 1999), LR 29:2436 (November 2003), amended LR 31:2903 (November 2005).

§505. Policy Provisions

A. Except for permitted preexisting condition clauses as described in §510.A.1. and §515.A.1 of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits, which duplicate benefits provided by Medicare.

D.1. Subject to §§510.A.1(d), (e), and (g), and 515.A.1(d) and (e), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

2. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

3. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

a. the policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

b. premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999), repromulgated LR 25:1483 (August 1999), LR 29:2436 (November 2003), amended LR 31:2904 (November 2005).

§506. Premium Increase Requirements

A. Every insurer issuing or renewing a Medicare supplement policy shall notify the policyholder and each member of an association in writing at least 45 days before any premium increase.

B. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate stating in substance that policyholder or certificateholder will be notified at least 45 days before any premium increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 29:2437 (November 2003), repromulgated LR 31:2904 (November 2005).

§507. Rate Increases Requirements

A. Every insurer issuing a Medicare supplement policy shall not increase their premium rates during the initial 12 months of coverage and not more than once in any six-month period following the initial 12-month period for any policy, certificate, rider, or amendment issued in or for residents of the state, no matter the date of commencement or renewal of coverage. This Subsection does not affect increases in the premium amount due to the addition of a newly covered person or change in age or geographic location of an individual insured or policyholder or an increase in the policy benefit level.

B. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate stating in substance that the premium rates will not increase during the initial 12-months of coverage and not more than once in any six-month period following the initial 12-month period. The notice may include that this requirement does not affect increases in the premium amount due to the addition of a newly covered person or change in age or geographic location of an individual insured or policyholder or an increase in the policy benefit level.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 29:2437 (November 2003), repromulgated LR 31:2904 (November 2005).

§508. Reserved.

§509. Reserved.

§510. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 20, 1992

A. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

1. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate 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.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. A noncancellable, guaranteed renewable, or noncancellable and guaranteed renewable Medicare supplement policy shall not:

i. provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

ii. be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e.i. Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

ii. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in §510.A.1.e.iv, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(a). an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(b). an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in §515.A.2 of this regulation;

(c). group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This Section is not intended to impair those obligations.

iii. If membership in a group is terminated, the issuer shall:

(a). offer the certificateholder the conversion opportunities described in §510.A.1.e.ii; or

(b). at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

iv. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this Subsection.

2. Minimum Benefit Standards

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

d. upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductibles ($110);

g. effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1103 (June 1999), repromulgated LR 25:1483 (August 1999), amended LR 29:2437 (November 2003), LR 31:2905 (November 2005).

§511. Reserved.

§512. Reserved.

§513. Reserved.

§514. Reserved.

§515. Benefit Standards for Policies or Certificates Issued or Delivered on or after July 20, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 20, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

1. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may 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.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy shall be guaranteed renewable.

i. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

ii. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under §515.A.1.e.v, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(a). provides for continuation of the benefits contained in the group policy; or

(b). provides for benefits that otherwise meet the requirements of this Subsection.

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(a). offer the certificateholder the conversion opportunity described in §515.A.1.e.iii; or

(b). at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

v. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

vi. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this Paragraph.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g.i. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months), or upon discovery by the insurer that the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

ii. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

iii. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan [as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act]. If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

iv. Reinstitution of coverage as described in Clauses g.ii and iii:

(a). shall not provide for any waiting period with respect to treatment of preexisting conditions;

(b). shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(c). shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

2. Standards for Basic (Core) Benefits Common to Benefit Plans A-J. Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it:

a. coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

d. coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. coverage for the coinsurance amount (or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

3. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by §520 of this regulation.

a. Medicare Part A Deductible—coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled Nursing Facility Care—coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B Deductible—coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B Excess Charges—coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. One hundred percent of the Medicare Part B Excess Charges—coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic Outpatient Prescription Drug Benefit—coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

g. Extended Outpatient Prescription Drug Benefit—coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

h. Medically Necessary Emergency Care in a Foreign Country—coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, emergency care shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive Medical Care Benefit—coverage for the following preventive health services not covered by Medicare:

i. an annual clinical preventive medical history and physical examination that may include tests and services from Clause ii and patient education to address preventive health care measures;

ii. preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

> Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-Home Recovery Benefit—coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

i. For purposes of this benefit, the following definitions shall apply:

Activities of Daily Living—include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

At-Home Recovery Visit—the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

Care Provider—a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

Home—any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

ii. Coverage Requirements and Limitations

(a). At-home recovery services provided must be primarily services, which assist in activities of daily living.

(b). The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(c). Coverage is limited to:

(i). no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii). the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(iii). $1,600 per calendar year;

(iv). seven visits in any one week;

(v). are furnished on a visiting basis in the insured's home;

(vi). services provided by a care provider as defined in this Section;

(vii). at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(viii). at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

iii. Coverage is excluded for:

(a). home care visits paid for by Medicare or other government programs; and

(b). care provided by family members, unpaid volunteers, or providers who are not care providers.

4. Standards for Plans K and L

a. Standardized Medicare supplement benefit plan "K" shall consist of the following:

i. coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

ii. coverage of 100 hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

iii. upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

iv. Medicare Part A Deductible. Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Clause x;

v. Skilled Nursing Facility Care. Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Clause x;

vi. Hospice Care. Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Clause x;

vii. Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Clause x;

viii. except for coverage provided in Clause xi below, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Clause x below;

ix. coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

x. coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

5. Standardized Medicare supplement benefit plan "L" shall consist of the following:

a. the benefits described in Clauses a.i-iii;

b. the benefit described in Clauses a.iv-viii, but substituting 75 percent for 50 percent; and

c. the benefit described in Clause a.x but substituting $2000 for $4,000.

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§516. Reserved.

§517. Reserved.

§518. Reserved.

§519. Reserved.

§520. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in §515.A.2 of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in §520.G and in §525 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this Subsection and conform to the definitions in §503 of this regulation. Each benefit shall be structured in accordance with the format provided in §§515.A.2 and 515.A.3 or 515.A.4 and list the benefits in the order shown in this Subsection. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-Up of Benefit Plans

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in §515.A.2 of this regulation.

2. Standardized Medicare supplement benefit plan "B" shall include only the following. The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible as defined in §515.A.3.a.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country, as defined in §515.A.3.a, b, c and h, respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in §515.A.3.a, b, h and j, respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in §515.A.3.a, b, h and i, respectively.

6. Standardized Medical supplement benefit plan "F" shall include only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in §515.A.3.a, b, c, e and h, respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in §515.A.3.a, b, c, e and h, respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in §515.A.3.a, b, d, h and j, respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country, as defined in §515.A.3.a, b, f and h, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in §515.A.3.a, b, e, f, h and j, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in §515.A.3.a, b, c, e, g, h, i and j, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in §515.A.3.a, b, c, e, g, h, i and j, respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

F. Make-up of two Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in §515.A.4(1).

2. Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in §515.A.4(2).

G. New or Innovative Benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1106 (June 1999), repromulgated LR 25:1487 (August 1999), LR 29:2440 (November 2003), amended LR 31:2909 (November 2005).

§521. Reserved.

§522. Reserved.

§523. Reserved.

§524. Reserved.

§525. Medicare Select Policies and Certificates

A.1. This Section shall apply to Medicare select policies and certificates, as defined in this Section.

2. No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this Section.

B. For the purposes of this Section:

Complaint—any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers.

Grievance—dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers.

Medicare Select Issuer—an issuer offering, or seeking to offer, a Medicare select policy or certificate.

Medicare Select Policy or *Medicare Select Certificate*—respectively a Medicare supplement policy or certificate that contains restricted network provisions.

Network Provider—a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy.

Primary Residence—the policyholder's residence as listed on the policyholder's application for insurance or any other residence given by the policyholder to the issuer subsequent to the application date for the purpose of changing the policyholder's residence.

Restricted Network Provision—any provision, which conditions the payment of benefits, in whole or in part, on the use of network providers.

Service Area—the 50 mile geographical radius or area approved by the commissioner within which a policyholder's primary residence must be located in relation to an issuer's network provider and within which an issuer is authorized to offer a Medicare select policy.

C. The commissioner may authorize an issuer to offer a Medicare select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D.1. A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

2. After September 1, 2006, issuers shall be prohibited from selling new Medicare select policies to those persons whose primary residence is located outside of the issuer's service area.

3. Medicare select issuers shall provide notice, within 30 days after the publication of this rule, to all Medicare select policyholders that:

a. if the policyholder changes his primary residence to a residence located outside of the issuer's service area:

i. the policyholder shall have the right to convert his current Medicare select policy to a Medicare supplement policy; and

ii. the issuer cannot cancel the policyholder's Medicare select policy on the basis that the policyholder did not convert his Medicare select policy to a Medicare supplement policy;

iii. the terms of the policy shall govern with respect to benefits available to the policyholder after moving his primary residence outside of the service area;

b. the policyholder may incur a penalty in the form of some or all of the benefits under the Medicare select policy not being payable if the policyholder requires medical services outside of the service area after the policyholder changes his primary residence to a residence located outside of the service area without converting his policy to a Medicare supplement policy.

4. After October 1, 2006, upon the Medicare select issuer obtaining actual knowledge that a policyholder has changed his primary residence to a residence located outside of the service area, the issuer shall mail to the policyholder the same notice, or one substantially similar, required in the above Paragraph D.3. The issuer shall mail this notice within 30 days after obtaining actual knowledge of the policyholder's change of residence.

E. A Medicare select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

1. evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and 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 the usual travel times within the community;

b. the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

i. to deliver adequately all services that are subject to a restricted network provision; or

ii. to make appropriate referrals;

c. there are written agreements with network providers describing specific responsibilities;

d. emergency care is available 24 hours per day and seven days per week;

e. in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This Paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

2. a statement or map providing a clear description of the service area;

3. a description of the grievance procedure to be utilized;

4. a description of the quality assurance program, including:

a. the formal organizational structure;

b. the written criteria for selection, retention and removal of network providers; and

c. the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

5. a list and description, by specialty, of the network providers;

6. copies of the written information proposed to be used by the issuer to comply with §525.I;

7. any other information requested by the commissioner.

F.1. A Medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

2. An updated list of network providers shall be filed with the commissioner at least quarterly.

G. A Medicare select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1. the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2. it is not reasonable to obtain such services through a network provider.

H. A Medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare select issuer shall make full and fair disclosure, in writing, of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure shall include at least the following:

1. an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

a. other Medicare supplement policies or certificates offered by the issuer; and

b. other Medicare select policies or certificates;

2. a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

3. a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Plans K and L;

4. a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. a description of limitations on referrals to restricted network providers and to other providers;

6. a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer;

7. a description of the Medicare select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this Section and that the applicant understands the restrictions of the Medicare select policy or certificate.

K. A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include non-binding arbitration procedures.

1. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.1. At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for six months.

2. For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select

policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1108 (June 1999), repromulgated LR 25:1488 (August 1999), amended LR 29:2442 (November 2003), LR 31:2910 (November 2005), LR 32:1462 (August 2006).

§526. Reserved.

§527. Reserved.

§528. Reserved.

§529. Reserved.

§530. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this Subsection without regard to age.

B.1. If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this Subsection.

C. Except as provided in Subsection B and §§535 and 590, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1110 (June 1999), repromulgated LR 25:1490 (August 1999), LR 29:2444 (November 2003), amended LR 31:2912 (November 2005).

§531. Reserved.

§532. Reserved.

§533. Reserved.

§534. Reserved.

§535. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue

1. Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons. An eligible person is an individual described in any of the following Paragraphs.

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual or the individual leaves the plan;

2. the individual is enrolled with a Medicare advantage organization under a Medicare advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare advantage plan:

a. the certification of the organization or plan has been terminated, or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

b. the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

c. the individual demonstrates, in accordance with guidelines established by the secretary, that:

i. the organization offering the plan substantially violated a material provision of the organization's contract under this Part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

ii. the organization, or agent or other entity acting on theorganization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

d. the individual meets such other exceptional conditions as the secretary may provide;

3.a. the individual is enrolled with:

i. an eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

ii. a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. an organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

iv. an organization under a Medicare select policy; and

b. the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under §535.B.2;

4. the individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a.i. of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

ii. of other involuntary termination of coverage or enrollment under the policy;

b. the issuer of the policy substantially violated a material provision of the policy; or

c. the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.a. the individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare advantage organization under a Medicare advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare select policy; and

b. the subsequent enrollment under Subparagraph a is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment [during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act]; or

6. the individual, upon first becoming enrolled for benefits under Medicare Part B, enrolls in a Medicare advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not later 12 months after the effective date of enrollment;

7. the individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph E.4.

C. Guaranteed Issue Time Periods

1. In the case of an individual described in Paragraph B.1, the guaranteed issue period begins on the later of:

a. the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or

b. the date that the applicable coverage terminates or ceases; and ends 63 days thereafter;

2. in the case of an individual described in Paragraphs B.2, 3, 5 or 6 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

3. in the case of an individual described in Subparagraph B.4.a, the guaranteed issue period begins on the earlier of:

a. the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and

b. the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated;

4. in the case of an individual described in Paragraphs B.2, 4.b, 4.c, 5 or 6 who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date;

5. in the case of an individual described in Paragraph B.7, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882 (v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60 period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

6. in the case of an individual described in Subsection B but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods

1. In the case of an individual described in Paragraph B.5 (or deemed to be so described, pursuant to this Paragraph) whose enrollment with an organization or provider described in Subparagraph B.5.a is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in §535.B.5;

2. in the case of an individual described in Paragraph B.6 (or deemed to be so described, pursuant to this Paragraph) who enrollment with a plan or in a program described in Paragraph B.6 is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in §535.B.6; and

3. for purposes of Paragraphs B.5 and B.6, no enrollment of an individual with an organization or provider described in Subparagraph B.5.a, or with a plan or in a program described in Paragraph B.6, may be deemed to be an initial enrollment under this Paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

1. §535.B.1.2.3 and 4 is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer;

2.a. subject to Subparagraph b, §535.B.5 is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in §535.E.1;

b. after December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this Subparagraph is:

i. the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

ii. at the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

3. §535.B.6 shall include any Medicare supplement policy available by any issuer;

4. §535.B.7 is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

F. Notification Provisions

1. At the time of an event described in Subsection B of this Section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in Subsection B of this Section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under §535.A. Such notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1110 (June 1999), repromulgated LR 25:1490 (August 1999), amended LR 29:2444 (November 2003), LR 31:2912 (November 2005).

§536. Reserved.

§537. Reserved.

§538. Reserved.

§539. Reserved.

§540. Standards for Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

1. accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other

claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. notifying the participating physician or supplier and the beneficiary of the payment determination;

3. paying the participating physician or supplier directly;

4. furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

5. paying user fees for claim notices that are transmitted electronically or otherwise; and

6. providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1111 (June 1999), repromulgated LR 25:1491 (August 1999), LR 29:2446 (November 2003), amended LR 31:2914 (November 2005).

§541. Reserved.

§542. Reserved.

§543. Reserved.

§544. Reserved.

§545. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

1.a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

i. at least 75 percent of the aggregate amount of premiums earned in the case of group policies; or

ii. at least 65 percent of the aggregate amount of premiums earned in the case of individual policies.

b. The percentages for Clauses A.1.a.i and ii shall be calculated 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 for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

i. home office and overhead costs;

ii. advertising costs;

iii. commissions and other acquisition costs;

iv. taxes;

v. capital costs;

vi. administrative costs; and

vii. claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For purposes of applying Paragraph A.1 of this Section and §550.D.3 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to January 20, 1991, expected claims in relation to premiums shall meet:

a. the originally filed anticipated loss ratio when combined with the actual experience since inception;

b. the appropriate loss ratio requirement from §545.A.1.a.i. and ii. when combined with actual experience beginning with January 1, 1998 to date; and

c. the appropriate loss ratio requirement from §545.A.1.a.i. and ii. over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation

1. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If, on the basis of the experience as reported, the benchmark ratio since inception (Ratio 1) exceeds the adjusted experience ratio since inception (Ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this Section, policies or certificates issued prior to January 20, 1991, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1998. The first report shall be due by May 31, 2000.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Filing of Rates and Rating Schedules. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

1. Each Medicare supplement policy or certificate form shall be accompanied, upon submission for approval, by an original and one copy of an actuarial memorandum. The memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the information listed in the following Subparagraphs:

a. the form number that the actuarial memorandum addresses;

b. a brief description of benefits provided;

c. a schedule of rates to be used;

d. a certification that the anticipated lifetime loss ratio is at least 65 percent (for individual coverage) or at least 75 percent (for group coverage);

e. a table of anticipated loss ratio experience for each year from issue over a reasonable number of years;

f. a certification that the premiums are reasonable in relation to the benefits provided; and

g. the entire filing shall be provided in duplicate;

h. any additional information requested by the commissioner.

2. Subsequent rate adjustments filings, except for those rates filed solely due to a change in the Part A calendar year deductible, shall also provide an original and one copy of an actuarial memorandum, prepared, signed and dated by a qualified actuary, in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the following:

a. the form number addressed by the actuarial memorandum;

b. a brief description of benefits provided;

c. a schedule of rates before and after the rate change;

d. a statement of the reason and basis for the rate change;

e. a demonstration and certification by the qualified actuary showing that the past plus future expected experience after the rate change will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio:

i. this rate change and demonstration shall be based on the experience of the named form in Louisiana only, if that experience is credible;

ii. the rate change and demonstration shall be based on experience of the named form nationwide, if the named form is used nationwide and the Louisiana experience is not credible, but the nationwide experience is credible;

f. for policies or certificates in force less than three years, a demonstration shall be included to show that the third-year loss ratio is expected to be equal to, or greater than, the applicable percentage;

g. a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided;

h. the entire filing shall be provided in duplicate;

i. any additional information requested by the commissioner.

3.a. An issuer of Medicare supplement policies and certificates issued before or after the effective date of Regulation 33 (Revised, 1992) in this state shall file annually no later than December 31 its rates for the upcoming calendar year. Also, supporting documentation including ratios of incurred losses to earned premiums by policy duration shall be submitted for approval by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

b. The filing for purposes of this Subsection shall contain all Medicare supplement plans issued by the issuer and shall not include rate adjustments. An actuarial memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the following:

i. the form number for each plan;

ii. plan type designation (for example: Plan A, Plan B, Pre -standardized);

iii. the rates for each plan;

iv. yearly loss ratios for each plan;

v. lifetime expected loss ratios for each plan;

vi. identify filing as "ANNUAL MEDICARE SUPPLEMENT FILING" on the face page of the memorandum;

vii. the entire filing shall be provided in duplicate;

viii. any additional information requested by the commissioner.

4. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

a. appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing;

b. an issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date;

c. if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

5. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Regulation 33 as revised July 20, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1112 (June 1999), repromulgated LR 25:1492 (August 1999), amended LR 29:2446 (November 2003), LR 31:2915 (November 2005).

§546. Reserved.

§547. Reserved.

§548. Reserved.

§549. Reserved.

§550. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

D.1. Except as provided in Paragraph D.2 of this Section, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

a. the inclusion of new or innovative benefits;

b. the addition of either direct response or agent marketing methods;

c. the addition of either guaranteed issue or underwritten coverage;

d. the offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this Section, a *type* means an individual policy, a group policy, an individual Medicare select policy, or a group Medicare select policy.

E.1. Except as provided in Subparagraph E.1.a, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner, in writing, its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph a shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this Subsection.

3. A change in the rating structure or methodology shall be considered a discontinuance under Paragraph E.1 unless the issuer complies with the following requirements.

a. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

b. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential, which is in the public interest.

F.1. Except as provided in Paragraph F.2, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in §545 of this regulation.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

G.1. An issuer that fails to implement an approved rate increase within six months after the approval date shall be prohibited from implementing such increase on future dates. The issuer shall notify the commissioner when any approved rate increase has not been implemented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1113 (June 1999), repromulgated LR 25:1494 (August 1999), amended LR 29:2448 (November 2003), LR 31:2917 (November 2005).

§551. Reserved.

§552. Reserved.

§553. Reserved.

§554. Reserved.

§555. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this Section, *compensation* includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999), repromulgated LR 25:1494 (August 1999), LR 29:2449 (November 2003), amended LR 31:2917 (November 2005).

§556. Reserved.

§557. Reserved.

§558. Reserved.

§559. Reserved.

§560. Required Disclosure Provisions

A. General Rules

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders

or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to, in writing, signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6.a. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12 point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates, as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application, and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

b. For the purposes of this Section, *form* means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements

1. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

a. include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

b. inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

C. MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

2. if an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

> "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3.a. the outline of coverage provided to applicants pursuant to this Section consists of four parts:

i. a cover page;

ii. premium information;

iii. disclosure pages; and

iv. charts displaying the features of all benefit plans available by the issuer;

b. the outline of coverage shall be in the language and format prescribed below in no less than 12 point type. All plans A-L shall be shown on the cover page, and each Medicare supplement policy and certificate currently available by an issuer shall be prominently identified. Premium information for plans that are available shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are available to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated;

4. the following items shall be included in the outline of coverage in the order prescribed below:

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page: 1 of 2

Benefit Plan(s)_____[insert letter(s) of plan(s) available from the issuer]

These Charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan A. Some plans may not be available in [Louisiana].

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (Generally, 20% of Medicare-approved expenses), or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
A	**B**	**C**	**D**	**E**	**F**	**F***	**G**	**H**	**I**	**J**	**J***
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plan F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not, include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out of Pocket Annual Limit***	$[2000] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult The Medicare Handbook for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to §520.D of this regulation.] [Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Plan A

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$0	$[912](Part A Deductible)
61st thru 90th day		$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[228] a day	$[456] a day	$0
--Once lifetime reserve days are used:	All but $[456] a day	100% of Medicare Eligible Expenses	
--Additional 365 days	$0		$0
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	$0	Up to $[114] a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare Approved Amounts*	$0	$0	$[110](Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare Approved Amounts*	$0	$0	$[110](Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services—Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare Approved Amounts*	$0	$0	$[110](Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Plan B

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912](Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	$0	Up to $[114] a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan B

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare- Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services--			
Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan C

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912](Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days		$0	$0
21st thru 100th day		Up to $[114] a day	$0
101st day and after		$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan C

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

Other Benefits—Not Covered by Medicare

Foreign Travel—Not Covered By Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan D

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days			
61st thru 90th day	All but $[912]	$[912](Part A Deductible)	$0
91st day and after:	All but $[228] a day	$[228] a day	$0
--While using 60 lifetime reserve days			
--Once lifetime reserve days are used:	All but $[456] a day	$[456] a day	$0
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

Services	Medicare Pays	Plan Pays	You Pay
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[110] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 $0 Generally, 80%	 $0 Generally, 20%	 $[110] (Part B Deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood First 3 pints Next $[110] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 $0 $0 80%	 All Costs $0 20%	 $0 $[110] (Part B Deductible) $0
Clinical Laboratory Services— Tests For Diagnostic Services	 100%	 $0	 $0

Plan D (continued)
Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First $[110] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $[110] (Part B Deductible) $0
At-Home Recovery Services—Not Covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan --Benefit for each visit --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) --Calendar year maximum	 $0 $0 $0	 Actual Charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance

Other Benefits—Not Covered by Medicare

Foreign Travel--Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Plan E

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912](Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan E

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare- Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan E (Continued)

Other Benefits—Not Covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
*****Preventive Medical Care Benefit—Not Covered by Medicare** Some annual physical and preventive tests and services, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All Costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People* with Medicare.

Plan F or High Deductible Plan F

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Services	Medicare Pays	[After You Pay [$1690] Deductible,** Plan Pays]	[In Addition to [$1690] Deductible,** You Pay]
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	 All but $[912] All but $[228] a day All but $[456] a day $0 $0	 $[912](Part A Deductible) $[228] a day $[456] a day 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but $[114] a day $0	 $0 Up to $[114] a day $0	 $0 $0 All costs
Blood First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance on any difference between its billed charges and the amount Medicare would have paid.

Plan for High Deductible Plan F (Continued)
Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Services	Medicare Pays	[After You Pay $1690 Deductible,** Plan Pays]	[In Addition to $1690 Deductible,** You Pay]
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Tests For Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment	$0	$[110] (Part B Deductible)	$0
First $[110] of Medicare-Approved Amounts*	80%	20%	$0
Remainder of Medicare-Approved Amounts			

Plan for High Deductible Plan F (Continued)

Other Benefits—Not Covered by Medicare

Services	Medicare Pays	After You Pay $1690 Deductible,** Plan Pays	In Addition to $1690 Deductible,** You Pay
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912] (Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs

Services	Medicare Pays	Plan Pays	You Pay
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan G

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Blood Tests For Diagnostic Services	100%	$0	$0

Plan G (Continued)

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
At-Home Recovery Services—Not Covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

Other Benefits—Not Covered by Medicare

Foreign Travel--Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan H

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912](Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan H

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services—			
Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan H (Continued)

Other Benefits—Not Covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel—Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	$0	$0	$250
First $250 each calendar year	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
Remainder of Charges			

Plan I

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912](Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan I

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services—			
Tests for Diagnostic Services	100%	$0	$0

Plan I (Continued)
Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$0	$[110] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
At-Home Recovery Services—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

Other Benefits—Not Covered by Medicare

Foreign Travel—Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan J or High Deductible Plan J

Medicare (Part A)—Hospital Services—Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.]

Services	Medicare Pays	[After You Pay [$1690] Deductible, ** Plan Pays]	[In Addition to [$1690] Deductible, ** You Pay]
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[912](Part A Deductible)	$0
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[114] a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan J or High Deductible Plan J (Continued)

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

Services	Medicare Pays	[After You Pay [$1650] Deductible, ** Plan Pays]	[In Addition to [$1650] Deductible, ** You Pay]
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All Costs	$0
Next $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Tests For Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[110] of Medicare-Approved Amounts*	$0	$[110] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan J or High Deductible Plan J (Continued)

Medicare (Part B)—Medical Services—Per Calendar Year

Parts A and B (Continued)

Services	Medicare Pays	[After You Pay[$1690] Deductible, ** Plan Pays]	[In Addition to [$1690] Deductible, ** You Pay]
Home Health Care (Cont'd)			
At-Home Recovery Services—Not Covered by Medicare			
Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare- Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

Plan J or High Deductible Plan J (Continued)

Parts A and B (Continued)

Other Benefits—Not Covered by Medicare

Services	Medicare Pays	After You Pay $1690 Deductible, ** Plan Pays	In Addition to $1690 Deductible, ** You Pay
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***Preventive Medical Care Benefit—Not Covered by Medicare** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People* with Medicare.

Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare (Part A)—Hospital Services—Per Benefit Period

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay*
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[456](50% of Part A deductible)	$[456](50% of Part A deductible)♦
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare eligible expenses	$0***
--Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[57] a day	Up to $[57] a day ♦
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

***NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan K

Medicare (Part B)—Medical Services—Per Calendar Year

****Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare Approved Amounts****	$0	$0	$[110] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4000])*
Blood			
First 3 pints	$0	50%	50%♦
Next $[110] of Medicare Approved Amounts****	$0	$0	$[110] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Clinical Laboratory Services— Tests For Diagnostic Services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan K

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay*
Home Health Care MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $[110] of Medicare Approved Amounts*****	$0	$0	$[110] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare (Part A)—Hospital Services—Per Benefit Period

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay*
Hospitalization**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[912]	$[684] (75% of Part A deductible)	$[228] (25% of Part A deductible)♦
61st thru 90th day	All but $[228] a day	$[228] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[456] a day	$[456] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare eligible expenses	$0***
--Beyond the additional 365 days	$0	$0	All costs

Services	Medicare Pays	Plan Pays	You Pay*
Skilled Nursing Facility Care**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[114] a day	Up to $[85.50] a day	Up to $[28.50] a day♦
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

***NOTE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan L

Medicare (Part B)—Medical Services—Per Calendar Year

****Once you have been billed $[110] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
Medical Expenses—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[110] of Medicare Approved Amounts****	$0	$0	$[110] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2000])*
Blood			
First 3 pints	$0	75%	25%♦
Next $[110] of Medicare Approved Amounts****	$0	$0	$[110] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services— Tests For Diagnostic Services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan L

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay*
Home Health Care			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $[110] of Medicare Approved Amounts*****			
Remainder of Medicare Approved Amounts	$0	$0	$[110] (Part B deductible) ♦
	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §1395 et seq.), disability income policy; or other policy identified in §502.B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"This [policy or certificate] is not a Medicare supplement [policy or contract]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph E.1 shall disclose, using the applicable statement in §598, Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999), repromulgated LR 25:1495 (August 1999), amended LR 29:2449 (November 2003), LR 31:2918 (November 2005).

§561. Reserved.

§562. Reserved.

§563. Reserved.

§564. Reserved.

§565. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or an other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

B. An application for a Medicare supplement policy shall not be combined with an application for any other type of insurance coverage. The application may not make reference to or include questions regarding other types of insurance coverage except for those questions specifically required under this Section.

1. [Statements]

a. You do not need more than one Medicare supplement policy.

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

d. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

e. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

f. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

2. [Questions]

a. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. Please answer all questions. [Please mark Yes or No below with an "X"]

i. To the best of your knowledge:

(a). Did you turn age 65 in the last 6 months? Yes____ No____

(b). Did you enroll in Medicare Part B in the last 6 months? Yes____ No____

(c).If yes, what is the effective date? _____

ii. Are you covered for medical assistance through the state Medicaid program? Yes____ No____ If yes:

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

(a). Will Medicaid pay your premiums for this Medicare supplement policy? Yes____ No____

(b). Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes____ No____

iii.(a). If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b). If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes____ No____

(c). Was this your first time in this type of Medicare plan? Yes____ No____

(d). Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes____ No____

iv.(a). Do you have another Medicare supplement policy in force? Yes____ No____

(b). If so, with what company, and what plan do you have [optional for Direct Mailers]? _____

(c). If so, do you intend to replace your current Medicare supplement policy with this policy? Yes____ No____

v. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes____ No____

(a). If so, with what company and what kind of policy? _____

_____

_____

(b). What are your dates of coverage under the other policy? START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

C. Agents shall list any other health insurance policies they have sold to the applicant:

1. list policies sold which are still in force;

2. list policies sold in the past five years, which are no longer in force.

D. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

E. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice, signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant, at the time of the issuance of the policy, the notice regarding replacement of Medicare supplement coverage.

F. The notice required by Subsection E above for an issuer shall be provided in substantially the following form in no less than 12 point type.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefit, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____

_____

Other. (please specify) _____

_____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

G. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1130 (June 1999). repromulgated LR 25:1510 (August 1999), LR 29:2474 (November 2003), amended LR 31:2937 (November 2005).

§566. Reserved.

§567. Reserved.

§568. Reserved.

§569. Reserved.

§570. Filing Requirements for Advertising

A. An issuer 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 of insurance of this state for review and approval by the commissioner to the extent permitted under the Insurance Code, particularly under R.S. 22:1215.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1131 (June 1999), repromulgated LR 25:1512 (August 1999), LR 29:2476 (November 2003), amended LR 31:2939 (November 2005).

§571. Reserved.

§572. Reserved.

§573. Reserved.

§574. Reserved.

§575. Standards for Marketing

A. An issuer, directly or through its producers, shall:

1. establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

2. establish marketing procedures to assure excessive insurance is not sold or issued;

3. display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses;"

4. inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance;

5. establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Louisiana Revised Statutes 22:1211 et seq. the following acts and practices are prohibited.

1. Twisting. Making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

2. High Pressure Tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Cold Lead Advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms *Medicare Supplement, Medigap, Medicare Wrap-Around* and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

D. No insurer providing Medicare supplement insurance in this state shall allow its agent to accept premiums except by check, money order, or bank draft made payable to the insurer. If payment in cash is made, the agent must leave the insurer's official receipt with the insured or the person paying the premium on behalf of the insured. This receipt shall bind the insurer for the monies received by the agent. Under this Section, the agent is prohibited from accepting checks, money orders and/or bank drafts payable to the agent or his agency. The agent is not to leave any receipt other than the insurer's for premium paid in cash.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1131 (June 1999), repromulgated LR 25:1512 (August 1999), LR 29:2476 (November 2003), amended LR 31:2939 (November 2005).

§576. Reserved.

§577. Reserved.

§578. Reserved.

§579. Reserved.

§580. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C (Medicare Advantage) unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999), repromulgated LR 25:1512 (August 1999), LR 29:2476 (November 2003), amended LR 31:2939 (November 2005).

§581. Reserved.

§582. Reserved.

§583. Reserved.

§584. Reserved.

§585. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

1. policy and certificate number; and
2. date of issuance.

B. The items set forth above must be grouped by individual policyholder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999), repromulgated LR 25:1512 (August 1999), LR 29:2476 (November 2003), amended LR 31:2939 (November 2005).

§586. Reserved.

§587. Reserved.

§588. Reserved.

§589. Reserved.

§590. Prohibition against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999), repromulgated LR 25:1512 (August 1999), LR 29:2477 (November 2003), LR 31:2940 (November 2005).

§591. Reserved.

§592. Reserved.

§593. Reserved.

§594. Reserved.

§595. Severability

A. If any Section or provision of this regulation, or the application to any person or circumstance, is held invalid, such invalidity or determination shall not affect other provisions or applications of this regulation which can be given effect without the invalid section or provision or application, and for these purposes the Sections and provisions or this regulation, and the applications, are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999), repromulgated LR 25:1513 (August 1999), LR 29:2477 (November 2003), amended LR 31:2940 (November 2005).

§596. Appendix A—Calculation Forms

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

Type[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

LINE		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a-1b		
2.	Past Year's Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (wee worksheet for Ratio 1)		
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) / Total Earned Prem. (line 3, col. a)-Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1. Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2. "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for pre-standardized plans.
3. Includes Modal Loadings and Fees Charged
4. Excludes Active Life Reserves
5. This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratio"

MEDICARE SUPPLMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR

Type[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims (Total Earned Premiums (Line 3, col. a) - Refund Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) - Refunds Inception (line 6) - [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to refunded or credited, a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name—Please Type

_____
Title

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR _____

Type[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
[3]Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
[6]To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR _____

Type[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
[3]Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
[6]To include the earned premium for all years prior to as well as the 15th year prior to the current year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999), repromulgated LR 25:1513 (August 1999), LR 29:2478 (November 2003), amended LR 31:2941 (November 2005).

§597. Appendix B—Medicare Supplement Policies Reporting Form

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1136 (June 1999), repromulgated LR 25:1516 (August 1999), LR 29:2482 (November 2003), LR 31:2943 (November 2005).

§598. Appendix C—Disclosure Statements

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificates) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State law and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not pre-empt state laws that are more stringent than the federal requirements.
8. The federal law does not pre-empt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not a Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ *For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1136 (June 1999), repromulgated LR 25:1516 (August 1999), LR 29:2483 (November 2003), amended LR 31:2944 (November 2005).

§599. Effective Date

A. This emergency regulation shall become effective upon publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1142 (June 1999), repromulgated LR 25:1522 (August 1999), amended LR 29:2497 (November 2003), LR 31:2948 (November 2005).

Chapter 7. Regulation 39—Statement of Actuarial Opinion

§701. Purpose

A. The purpose of this regulation is to implement Act 103 of the 1990 Regular Legislative Session. It is further intended to protect the public from the risk of insolvent insurance companies by requiring companies issuing certain types of policies to provide actuarial statement of opinion of loss and loss adjustment expense reserves. This will assist the agency in ensuring that adequate reserves are retained by insurers so that claims can be paid and minimize the necessity of putting companies into conservation and/or liquidation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:904.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:619 (June 1992).

§703. Applicability and Scope

A. This regulation shall apply to all companies which issue policies of personal injury liability insurance, policies of employer's liability insurance, and policies of worker's compensation insurance. Companies which issue these types of policies shall attach to page 1 of the annual statement the statement of a qualified actuary, entitled "Statement of Actuarial Opinion," setting forth his or her opinion relating to loss and loss adjustment expense reserves.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:904.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:619 (June 1992).

§705. Definitions

Annual Statement—the annual financial statement required to be filed by insurers with the commissioner.

Insurer—an insurer authorized to write property and/or casualty insurance under the laws of any state and includes, but is not limited to, fire and marine companies, general casualty companies, local mutual aid societies, statewide mutual assessment companies, mutual insurance companies other than life, farm mutual insurance companies, county mutual insurance companies, Lloyd's plans, reciprocal and

interinsurance exchanges, captive insurance companies, risk retention groups, stipulated premium insurance companies, and non-profit legal service corporations.

Qualified Actuary—a person who is either:

1. a member in good standing of the Casualty Actuarial Society; or

2. a member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinion by the Casualty Practice Council of the American Academy of Actuaries; or

3. a person who otherwise has competency in loss reserve evaluation as demonstrated to the satisfaction of the insurance regulatory official of domiciliary state. In such case, at least 90 days prior to the filing of its annual statement, the insurer must make a request to the commissioner that the person be deemed qualified. That request must be approved or denied by the commissioner or his designee. The request must include NAIC Biographical Form and a list of all loss reserve opinions and/or certifications issued in the last three years by this person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:904.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:619 (June 1992).

§707. Content

A. The "Statement of Actuarial Opinion" shall be in the format of and contain the information required by §12 of the Annual Statement Instructions: Property and Casualty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:904.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:619 (June 1992).

§709. Exemptions

A. Companies subject to this regulation may apply for an exemption. If an exemption is granted, a certified copy of the approved exemption must be filed with the annual statement in all jurisdictions in which the company is authorized to do business. An exemption may be applied for solely on the following grounds.

1. Automatic Exemption

a. An insurer, otherwise subject to this regulation, that has less than $1,000,000 total direct plus assumed written premiums during a calendar year or that has less than a total of 1,000 policyholders and certificate holders at the end of a calendar year, in lieu of the certification required for the calendar year, may submit an affidavit, under oath of an officer of the insurer, that specifies that amount of direct, plus assumed, premiums written and the total number of policyholders and certificate holders.

b. An insurer who intends to file for an exemption under §709 must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he deems the exemption inappropriate. If an insurer intends to file for an exemption for calendar year 1991, it must do so no later than January 31, 1992.

2. Exemption for Insurers under Supervision or Conservatorship

a. Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirement contained herein.

3. Exemption for Nature of Business

a. An insurer otherwise subject to this regulation and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of the business written. This exemption is available to those companies writing property lines only.

4. Financial Hardship Exemption

a. An insurer otherwise subject to this regulation and not eligible for any of the exemptions enumerated above may apply to the commissioner for a financial hardship exemption.

b. Financial hardship is presumed to exist if the projected reasonable cost of the certification would exceed the lesser of:

i. 1 percent of the insurer's capital and surplus reflected in the insurer's annual statement filed with the department for the calendar year for which the exemption is sought; or

ii. 3 percent of the insurer's net direct plus assumed premiums written during the calendar year for which the exemption is sought as reflected in the insurer's annual statement filed with its domiciliary commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:904.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:619 (June 1992).

Chapter 9. Regulation 40—Summary Document and Disclaimer and Notice of Noncoverage

§901. Purpose

A. The purpose of this regulation is to implement Act 998 of the 1991 Regular Legislative Session, entitled Louisiana Life and Health Insurance Guaranty Association (LLHIGA) as set forth in R.S. 22:1395.1, et seq., which is designed to protect covered persons against the risk of insurer insolvencies under certain life and health insurance policies.

B. The purpose of the documents is to give notice to the insurance-buying consumer that the LLHIGA Act includes restrictions as to coverage, and in some instances excludes coverage for certain types of policies or contracts, and includes substantial limitations as to the amounts which may be reimbursed in the event of the insolvency of the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1395.18(B)(C)(D) and 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:620 (June 1992), amended LR 18:1401 (December 1992).

§903. Applicability and Scope

A. This regulation applies to the Louisiana Life and Health Insurance Guaranty Association (LLHIGA) and its member insurers as defined by R.S.22:1395.3.

B. Exhibit A, which follows hereto and is made a part hereof, sets forth the form and content of the Summary Document, as approved by the Commissioner of Insurance on August 10, 1992, summarizes the coverage provided by the Act, and includes a Disclaimer statement which is to be conspicuously placed on the front of the Summary Document. Pursuant to R.S. 22:1395.18(B) the Summary Document with the Disclaimer is to be delivered with each life or health insurance policy, as described in R.S. 1395.3(B)(1), issued or delivered in Louisiana.

C. Exhibit B, which follows hereto and is made a part hereof, sets forth the Notice of Noncoverage required by R.S. 22:1395.18(D). It is required to be delivered with each policy or contract referred to in R.S. 22:1395.3(B)(1) and excluded from coverage under R.S. 22:1395.3(B)(2)(a).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1395.18(B)(C)(D) and 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:620 (June 1992), amended LR 18:1401 (December 1992).

§905. Form and Content

A. The Summary Document and Disclaimer shall be in a form which complies with §907, Exhibit A, which follows hereto and forming a part of this regulation.

B. The Notice of Noncoverage shall be in a form which complies with §909, Exhibit B, which follows hereto and forming a part of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1395.18(B)(C)(D) and 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:620 (June 1992), amended LR 18:1401 (December 1992).

§907. Exhibit A—Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

A. Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA	Department of Insurance
P.O. Drawer 44126	P. O. Box 94212
Baton Rouge, LA 70804	Baton Rouge, LA 70804-9214

B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

C. Coverage. Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

D. Exclusions from Coverage

1. However, persons holding such policies are not protected by this association if:

a. they are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state.);

b. the insurer was not authorized to do business in this state;

c. their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

2. The association also does not provide coverage for:

a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

b. any policy of reinsurance (unless an assumption certificate was issued);

c. interest rate yields that exceed an average rate;

d. dividends;

e. credits given in connection with the administration of a policy by a group contract holder;

f. employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

g. unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under §403(b) of the Internal Revenue Code, except that, even if qualified under §403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

E. Limits on Amounts of Coverage

1. The Act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1395.18(B)(C)(D) and 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:620 (June 1992), amended LR 18:1401 (December 1992).

§909. Exhibit B—Notice of Noncoverage

A. The Louisiana Life and Health Insurance Guaranty Association (LLHIGA) provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent.

THE POLICY OR CONTRACT YOU ARE PURCHASING IS NOT COVERED BY THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

Coverage is specifically excluded by law for the type of policy or contract you are purchasing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1395.18(B)(C)(D) and 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:620 (June 1992), amended LR 18:1401 (December 1992).

Chapter 11. Regulation 42—Group Self-Insurance Funds

§1101. Definitions

A. When used in this regulation, the following words or terms shall have the meaning as described in §1101.

Administrator—an individual, partnership, or corporation engaged by a group self-insurance fund to carry out the policies of the trustees of the fund and to provide day-to-day management of the fund.

Aggregate Losses—the amount of all claims, including reserves for loss development and losses incurred but not reported, which exceeds the loss fund.

Contingent Liability—the amount that a self-insurance fund may be obligated to pay in excess of a given fund year's normal premium collected or on hand.

Fiscal Agent—an individual, partnership, or corporation engaged by a self-insurance fund to carry out the fiscal policies of the fund, invest and disburse assets, and oversee the financial matters of the fund. An administrator may be a fiscal agent.

Gross Premium—premium determined by multiplying the payroll (segregated into the proper workers' compensation job classifications) times the manual premium rates approved by the commissioner.

Group Self-Insurance Fund or Fund—employers who enter into agreements to pool their workers compensation liabilities in accordance with Louisiana Revised Statutes 23:1191-1193.

Incurred but not Reported Reserves—a reserve established which estimates the incurred loss of claims whose existence is unknown by the fund or claims which have been reported but not recorded on the books of the fund.

Loss Development—the change in incurred loss from one point in time to another.

Loss Development Reserve—any amount needed in a given fund year, in addition to current loss reserves, to fund future loss development.

Loss Fund—the retention under the terms of an aggregate excess contract, or if no aggregate excess is purchased, the amount remaining from normal premium in each fund year after all necessary expenses are paid.

Normal Premium—standard premium less allowed discount.

Qualified Actuary—either:

a. an associate or fellow of the Casualty Actuarial Society; or

b. a member of the American Academy of Actuaries who demonstrates knowledge of workers compensation insurance.

Standard Premium—gross premium plus or minus applicable experience debits or credits.

Surplus—assets of a fund in excess of loss reserves, actual and contingent liabilities and loss development reserves in all fund years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1103. Application to Create a Group Self-Insurance Fund

A. All applications to create a group self-insurance fund shall meet the requirements of R.S. 23:1191-1193, any other applicable laws of the state of Louisiana, and this regulation.

B. Applications shall be made in writing on a form acceptable to the commissioner.

C. Applications shall be submitted to the Department of Insurance at least 60 days prior to the effective date for establishment of a fund. Any application submitted with less than 60 days remaining before the desired effective date, or which does not contain answers to all questions, or which is not notarized, may be returned without review by the commissioner.

D. All applications shall be accompanied by:

1. a properly completed indemnity agreement in a form acceptable to the commissioner, pursuant to §1111 of this regulation;

2. securities or a Self-Insurer's Surety Bond on a form and properly executed by a surety acceptable to the commissioner, pursuant to Louisiana Revised Statutes Title 23, §1192(A)(2) and this regulation;

3. copies of acceptable excess insurance policies, pursuant to Louisiana Revised Statutes Title 23, §1192(A)(3) and this regulation;

4. a fidelity bond covering the service company, pursuant to Louisiana revised Statutes Title 23, §1192(A)(7);

5. a certification from a designated depository attesting to the amount of monies on hand;

6. copies of the fund bylaws or trust agreement;

7. individual application of each member of the group applying for membership in the fund on the effective date of the fund;

8. proof that the initial members of the fund have the combined net worth and membership requirements as specified in Louisiana Revised Statutes Title 23, §1191 and this regulation;

9. proof that the fund shall have an annual gross premium as specified in Louisiana Revised Statutes Title 23, §I192(A)(1);

10. the current financial statement of any casualty insurance company writing excess coverage for the fund, which meets the requirements of Louisiana Revised Statutes Title 23, §1192(A)(6);

11. the name of the attorney representing the fund and the name of the certified public accountant who will be submitting the certified financial statement;

12. a completed estimated breakdown of policy year expenses on a form acceptable to the commissioner;

13. the address in this state where the books and records of the group will be maintained at all times;

14. proof of payment to the group self-insurance fund by each member of not less than 25 percent of that member's first year estimated annual net premium;

15. a pro forma financial statement, pursuant to Louisiana Revised Statutes Title 23, §1192(A)(8) and §5(A) hereof.

E. Upon receipt of the application and other required materials, the commissioner will investigate the application and will request any additional information which is required in a letter to the applicant.

F. Failure to meet any of the criteria or provide needed information shall be grounds for denial of the application.

G. Within 45 days of receipt of all requested information, the commissioner shall issue a decision approving or denying the application, or shall extend his time for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1105. Conditions for Retaining the Self-Insurance Privilege

A. The self-insurance privilege of a fund is granted continuously until revoked.

B. All funds shall be required to submit the following documents and reports:

1. annual financial statements certified by an independent certified public accountant pursuant to §1107.B hereof;

2. estimated breakdown of policy year expenses pursuant to §1107.D hereof;

3. actuarial reports as may be required by the commissioner;

4. changes in items required to be furnished under §1103.D.1, 2, 3, 4, 6, 10, 11, and 13 within 10 days of the effective date of such change.

C. All funds shall maintain a combined net worth of their members sufficient to pay all claims.

D. Each fund shall notify the commissioner, within 10 days of receiving knowledge thereof, of any claim, whether such claim is in litigation or otherwise, against the fund which, if the claimant is successful, would create an obligation of the fund to pay in excess of 50 percent of the fund's specific self-insured retention or $125,000, whichever is less.

E. The commissioner may prescribe the format and frequency of other reports which may include, but shall not be limited to, payroll audit reports, summary loss reports, and quarterly financial statements.

F. The commissioner may require periodic proof that the fund is complying with the applicable laws, rules, regulations, and directives of the Department of Insurance.

G. Whenever the commissioner determines that a fund has knowingly submitted an application or other information containing false or misleading information, the commissioner may revoke the Certificate of Authority of the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1107. Financial and Actuarial Reports for Group Self-Insurance Funds

A. Each fund shall submit a current financial statement, certified by an independent certified public accountant, of at least two members showing, at the inception of the fund, a combined net worth of a minimum of $500,000, current financial statements of all other members, a combined ratio of current assets to current liabilities of more than one to one, a combined working capital of an amount establishing financial strength and liquidity of the members to pay normal compensation claims promptly, and showing evidence of the financial ability of the group to meet its obligations. A certified audit or a financial statement properly certified by an officer, owner, or partner for all members joining the fund after the inception date shall be submitted to the commissioner until such time as a certified annual audit report is available for the fund as a whole. In no event shall the cumulative net worth or ratio of the current assets to current liabilities of all members be less than that required in §1107.A.

B. The report of financial condition shall be due annually within six months of the close of the fiscal year of the fund, unless an extension is granted by the commissioner, on a form acceptable to the commissioner.

C. Actuarial reviews, if required, shall be made by a qualified actuary. Actuarial reports shall be due and filed at the same time as the fund's annual financial statement, except as otherwise provided by the commissioner.

D. Each fund shall file an estimated breakdown of expenses on a form acceptable to the commissioner, within 60 days after the beginning of each fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1109. Excess Insurance Requirements for Group Self-Insurance Funds

A. All funds shall maintain specific excess insurance in the amount of at least $2,000,000 per occurrence and an aggregate excess of at least $2,000,000.

B. For the purposes of §1109, no loss fund shall be less than 70 percent of earned normal premium without the approval of the commissioner.

C. The maximum retention allowed for a fund's specific excess policy shall be in accordance with the following schedule unless a waiver is granted pursuant to §1109.D, E, F, and G:

1. for funds with a loss fund less than $50,000,000, the maximum retention shall be three percent of the fund's loss fund, or $250,000, whichever is greater;

2. for funds with a loss fund greater than or equal to $50,000,000 and less than $100,000,000, the maximum retention shall be 3.5 percent of the fund's loss fund;

3. or funds with a loss fund greater than or equal to $100,000,000, the maximum retention shall be 4 percent of the fund's loss fund;

4. regardless of any maximum contained in §1109.C, no fund shall secure a retention which in the commissioner's opinion is not actuarially sound.

D. If a fund wishes to secure a specific excess policy with a retention greater than the maximum allowed by §1109.C, then the fund shall comply with the procedure described in §1109.E, F, and G.

E. Funds which have been in operation at least 30 months may request permission to secure a retention higher than that authorized by §1109.C. A fund shall submit a feasibility study prepared by a qualified actuary which analyzes the impact on the fund of the higher retention.

F. The commissioner shall deny the use of a higher retention if he finds:

1. that the higher retention will have a significant adverse effect on the financial condition of the fund; or

2. that the fund is unable to establish reserves using monies from:

a. premium earned during the year the loss was incurred; or

b. investment earnings from the year in which the loss was incurred; or

c. from future investment earnings on the specific loss reserve.

G. Each fund shall provide security for aggregate losses by selecting one of the following alternatives:

1. purchasing an acceptable aggregate excess policy;

2. upon approval of the commissioner, post a cash security deposit in the amount of $1,000,000 or 20 percent of annual standard premium, whichever is greater; or

3. if the fund has been in operation at least 60 months, upon approval of the commissioner, establish an actuarially sound reserve for aggregate losses.

H. Subject to the minimum stated in §1109.A, the fund shall secure an aggregate limit of at least 20 percent of the annual standard premium of the fund for the term of the policy. The retention of the aggregate policy shall be subject to the approval of the commissioner.

I. If the option in §1109.G.2 is selected, a fund, upon approval of the commissioner, may self-insure part of its aggregate limit by posting as a cash security deposit for the amount which is self-insured.

J. If a fund receives permission to provide security for its aggregate losses by establishing an aggregate reserve, the fund shall comply with the following requirements.

1. At least 60 days prior to the beginning of each policy year for which an aggregate reserve will be established, the fund shall submit a plan for that year. Approval of the plan by the commissioner shall be required before an aggregate reserve may be established for the next policy year.

2. Within six months after the end of each fund year, the fund shall submit an actuarial review, by a qualified actuary, of its aggregate reserve for each fund year whose aggregate losses are guaranteed by the reserve.

3. Along with the actuarial review, the fund shall provide financial information which sets forth the financial position of the aggregate reserve.

4. In actuarially determining the amount of ultimate loss, the fund and its actuary may take into account current or future recoveries from any aggregate or specific excess contract, if such contract complies with this regulation.

K. The commissioner may:

1. reject an actuarial review or financial report which does not comply with the requirements of §1109.L. If this occurs, the commissioner may, at the expense of the fund, conduct his own actuarial or financial review, or, upon request of the fund, allow the fund to submit another actuarial or financial report, subject to the commissioner's approval of the party preparing the report;

2. for good cause, order a fund to cease using an aggregate reserve for securing its aggregate losses. Good cause shall include a finding that the aggregate reserve is actuarially unsound, that the fund is insolvent, that the fund will lack sufficient liquidity to run off its claims without reliance on future premium income, or that the fund has failed to comply with the provisions of this regulation;

3. in the event that the fund's aggregate reserve, or reserves, is actuarially unsound, order the fund to take such corrective action as necessary to make the reserve actuarially sound.

L. If a fund receives approval of its plan to use an aggregate reserve to provide security for its aggregate losses, then:

1. payment of dividends from premium in a fund year shall not be requested or approved for that fund year as long as any claims reserves, reserves for loss development, or reserves for losses incurred but not reported (IBNR) are unfunded by actual cash reserves;

2. no dividends shall be requested or approved from investment earnings unless the aggregate reserves for all years are actuarially sound, taking into account future contributions, and aggregate excess insurance;

3. advance premium discounts and all expenses unnecessary for the fund to meet its obligations will be reduced or eliminated, if necessary, to provide funds to make an aggregate reserve actuarially sound;

4. amounts actuarially determined to be necessary for the reserves for loss development and IBNR shall be a part of the fund's security deposit requirement;

5. no premium from a year prior to the year for which the aggregate reserve is established may be allocated to fund an aggregate reserve until 12 months after the close of the prior year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1111. Indemnity Agreement

A. Each self-insurance fund member shall enter into an indemnity agreement jointly and severally binding the self-insurance fund and each member thereof to comply with the provisions of the applicable Louisiana Revised Statutes and rules, regulations, and directives of the Department of Insurance.

B. The Indemnity Agreement requirement shall not be applicable to group self-insurance funds of public employers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1113. Rates and Reporting of Rates

A. Every workers' compensation self-insurance fund shall adhere to a uniform classification system, uniform experience rating plan, and manual rules approved by the commissioner. An experience modification shall be determined for each member of a self-insurance fund annually, or as otherwise provided, on the same basis as if the employer were insured under rules approved by the Louisiana Insurance Rating Commission for admitted carriers and such modification is to be used to determine the employer's standard premium as provided by such rules and the indemnity agreement. Should a member cease to participate in a self-insurance fund and purchase standard insurance coverage, self-insured experience may be used in the employer's future experience rating calculation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1115. Authorized Investments for Group Self-Insurance Funds

A. Amounts not needed for current obligations may be invested by the board of trustees in deposits in federally insured banks or savings and loan associations or in direct obligations of the United States government or direct obligations of the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1117. Premium Audit

A. All self-insurance funds shall determine the normal premium due from each member in each policy year based on actual audited payroll. Audits shall consist of physical on-site audits or mail self-audits. The requirements set forth herein shall apply to the fund and its present or former members. Funds shall be responsible for compliance with §1117 by contracted audit personnel or firms.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1119. Board of Trustees

A. Except upon approval of the commissioner, the fund's administrator, service company, or any owner, officer, employee of, or any other person affiliated with, such administrator or service company shall not serve on the board of trustees of the fund.

B. All trustees shall be residents of this state or officers of corporations authorized to do business in this state.

C. The board of trustees of each group shall ensure that all claims are paid promptly and take all necessary precautions to safeguard the assets of the group, including all of the following:

1. maintain responsibility for all monies collected or disbursed from the group and segregate all monies into a claims fund account and an administrative fund account. At least 70 percent of the premium, as determined by the commissioner, shall be designated for the sole purpose of paying claims, allocated claims expenses, and special fund contributions, including second injury and other loss related funds. This shall be called the claims fund account. The remaining net premium shall be designated for the payment of taxes, general regulatory fees, assessments, and administrative costs. This shall be called the administrative fund account. The commissioner may approve an administrative fund account of more than 30 percent and a claims fund account of less than 70 percent only if the group shows to the commissioner's satisfaction that:

a. more than 30 percent is needed for an effective safety and loss control program; or

b. the group's aggregate excess insurance attaches at less than 70 percent;

2. maintain minutes of its meetings;

3. designate an administrator to carry out the policies established by the board of trustees and to provide day-to-day management of the group, and delineate in the written minutes of its meetings the areas of authority it delegates to the administrator;

4. retain an independent certified public accountant to prepare the statement of financial condition required by §1107.A and B hereof;

5. the trustees shall cause to be adopted a set of by-laws or shall enter into a trust agreement which shall govern the operation of the fund.

D. The board of trustees shall not:

1. extend credit to individual members for payment of a premium, except pursuant to payment plans approved by the commissioner;

2. borrow any monies from the group or in the name of the group, except in the ordinary course of business, without first obtaining prior approval from the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1121. Group Membership; Termination, Liability

A. An employer joining a group after the group has been issued a certificate of approval shall:

1. submit an application for membership to the board of trustees or its administrator; and

2. enter into the indemnity agreement required by §1103.C.l hereof. Membership shall take effect no earlier than each member's date of approval. The application for membership and its approval shall be maintained as permanent records of the board of trustees.

B. Individual members of a group shall be subject to cancellation by the group's cancellation policy. In addition, individual members may elect to terminate their participation in the group.

C. The group shall pay all workers' compensation benefits for which each member incurs liability during its period of membership. A member who elects to terminate its membership or is canceled by a group remains liable jointly and in solido for claims of the group and its members which were incurred during the canceled or terminated member's period of membership.

D. A group member is not relieved of its workers' compensation liabilities incurred during its period of membership except through payment by the group or the member of required workers' compensation benefits.

E. The insolvency or bankruptcy of a member does not relieve the group or any other member of liability for the payment of any worker's compensation benefits incurred during the insolvent or bankrupt member's period of membership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1123. Service Companies

A. All service companies must file a request for approval by the commissioner and have a letter or certificate of approval from the commissioner prior to engaging in any service to a fund. All service companies performing services for group self-insurance funds on the effective date of this regulation shall file the request for approval and receive the letter or certificate of approval from the commissioner not later than March 1, 1993. The commissioner may request any information deemed necessary to establish the ability and financial strength of the service company to perform the required functions.

B. Except upon approval of the commissioner:

1. no service company or its employees, officers, or directors shall be an employee, officer, or director of, or have either a direct or indirect financial interest in, an administrator; and

2. no administrator or its employees, officers, or directors shall be an employee, officer, or director of, or have either a direct or indirect financial interest in, a service company.

C. The service contract shall state that, unless the commissioner approves otherwise, the service company shall handle, to their conclusion, all claims and other obligations incurred during the contract period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1125. Licensing of Agents

A. Any person soliciting membership for a fund must be licensed by the commissioner as a property and casualty agent; provided, however, that employees of a bona fide trade or professional association which has established a fund shall not be required to be so licensed if such solicitation is not the primary duty of such employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1127. Deficits and Insolvencies

A. Should the commissioner find a fund in danger of becoming insolvent, the fund shall make up any deficiency owed or shall submit a plan for elimination of the deficit to the commissioner in order that he may determine whether or not an assessment upon its members for the amount needed to make up the deficiency is required.

B. In the event of a deficiency in any fund year, such deficiency shall be made up immediately, either from:

1. surplus from a fund year other than the current fund year;

2. administrative funds;

3. assessment of the membership, if ordered by the fund; or

4. such alternative method as the commissioner may approve or direct. The commissioner shall be notified prior to any transfer of surplus funds from one fund year to another.

C. If the fund fails to assess its members, otherwise make up such deficit, or submit a plan, as specified in §1127.A, within 60 days of notice by the commissioner, the commissioner shall order assessment of the members of the fund.

D. If the fund fails to make the required assessment of its members within 30 days after the commissioner orders it to do so, or if the deficiency is not fully made up within 90 days after the date that such assessment is made, or within such longer period of time as may be specified by the commissioner, the fund shall be deemed to be insolvent.

E. For purposes of these provisions, a fund is insolvent if the fund is unable to pay its outstanding lawful obligations as they mature in the regular course of business.

F. In the event of liquidation of a fund, the commissioner shall levy an assessment upon its members for such amounts as the commissioner determines to be necessary to discharge all liabilities of the fund, including the reasonable costs of liquidation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1129. Review of Rate Determination

A. Funds shall provide reasonable means whereby any member aggrieved by the application of the fund's rating system may, in writing, request a review of the manner in which such rating system has been applied in connection with the coverage afforded. The fund shall have 30 days from receipt to grant or deny the request, in writing. If the fund rejects such request or fails to grant or reject such request within such 30-day period, the member may, within 30 days following the expiration of such 30-day period, appeal to the commissioner, who, after a hearing held upon not less than 10 days' written notice to the member and to the fund, may affirm or reverse such action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1131. Cease and Desist Orders

A. After notice and opportunity for a hearing, the commissioner may issue an order requiring a person or group to cease and desist from engaging in an act or practice found to be in violation of any provision of this regulation.

B. Upon finding, after notice and opportunity for a hearing, that any person or group has violated any cease and desist order, the commissioner may revoke the group's certificate of authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1133. Revocation of Certificate of Authority

A. After notice and opportunity for a hearing, the commissioner may revoke a group's certificate of authority if:

1. the group is found to be insolvent;

2. the group fails to pay any premium tax, regulatory fee, or assessment, or special fund contribution imposed upon it;

3. the group fails to comply with any of the provisions of this regulation, or with any lawful order of the commissioner within the time prescribed;

4. the certificate of authority issued to the group was obtained by fraud;

5. there was a material misrepresentation in the application for the certificate of authority; or

6. the group or its administrator has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any monies held in a fiduciary capacity that belong to a member, an employee of a member, or another person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

§1135. Examinations

A. The commissioner may examine the affairs, transactions, accounts, records, assets, and liabilities of a fund as often as the commissioner deems advisable. The expenses of such examinations shall be paid by the fund being examined.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1193.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1403 (December 1992).

Chapter 13. Regulation 43—Companies in Hazardous Financial Condition

§1301. Purpose

A. The purpose of this regulation is to set forth the standards which the Commissioner of Insurance (the "commissioner") may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.

B. This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of the state of Louisiana, nor shall this regulation be interpreted to supersede any laws or parts of laws of the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

§1303. Definitions

A. As used in this regulation, the following terms shall have the respective meaning hereinafter set forth:

Control—as defined in R.S. 22:1002(3).

Person—as defined in R.S. 22:1002(7).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

§1305. Standards

A. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors, or the general public. The commissioner may consider:

1. adverse findings reported in financial condition and market conduct examination reports or reported in required financial reports;

2. the National Association of Insurance Commissioners Insurance Regulatory Information System, its related reports and caveats;

3. the ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus;

4. the insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature;

5. the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written, as well as the financial condition of the assuming reinsurer;

6. the insurer's operating loss in the last 12-month period or any shorter period of time including, but not limited to, net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than 50 percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required;

7. whether any affiliate, subsidiary or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations;

8. contingent liabilities, pledges, or guarantees which either individually or collectively involve a total amount which, in the opinion of the commissioner, may affect the solvency of the insurer;

9. whether any person having control of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer;

10. the age and collectibility of receivables;

11. whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position;

12. whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

13. whether management of an insurer either has filed any false or misleading sworn financial statement, or has released any false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

14. whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; or

15. whether the insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

§1307. Commissioner's Authority

A. For the purposes of making a determination of an insurer's financial condition under this regulation, the commissioner may:

1. disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

2. make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

3. refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

4. increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise disclosed if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

B. If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner may, upon his determination, issue an order requiring the insurer to:

1. reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. reduce, suspend, or limit the volume of business being accepted or renewed;

3. reduce general insurance and commission expenses by specified methods;

4. increase the insurer's capital and surplus;

5. suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

6. file reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

7. limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

8. document the adequacy of premium rates in relation to the risks insured; or

9. file, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the commissioner;

10. if the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

C. Within 30 days of receipt of notification of the order of the commissioner to the insurer made pursuant to §1307.B, the insurer may make written demand for a hearing pursuant to the provisions of Part XXIX of Chapter I of Title 22 of the Louisiana Revised Statutes of 1950; provided, however, that such a hearing will be held privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2(H).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1408 (December 1992).

Chapter 15. Regulation 44—Accelerated Benefits

§1501. Purpose

A. The purpose of this regulation is to regulate accelerated benefit provisions of individual and group life insurance policies and to provide required standards of disclosure. This regulation shall apply to all accelerated benefits provisions of individual and group life insurance policies except those subject to the Long-Term Care Insurance Model Act, issued or delivered in this state, on or after the effective date of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1503. Definitions

Accelerated Benefits covered under this regulation—benefits payable under a life insurance contract:

1. to a policy owner or certificate holder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions, as defined by the policy or rider; and

2. which reduce the death benefit otherwise payable under the life insurance contract; and

3. which are payable upon the occurrence of a single qualifying event which results in the payment of a benefit amount fixed at the time of acceleration.

Qualifying Event—includes one or more of the following:

1. a medical condition which would result in a drastically limited life span as specified in the contract, for example, 24 months or less; or

2. a medical condition which has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die; or

3. any condition which usually requires continuous confinement in an eligible institution, as defined in the contract, if the insured is expected to remain there for the rest of his or her life; or

4. a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of he following:

a. coronary artery disease resulting in an acute infarction or requiring surgery;

b. permanent neurological deficit resulting from cerebral vascular accident;

c. end stage renal failure;

d. Acquired Immune Deficiency Syndrome; or

e. other medical conditions which the commissioner shall approve for any particular filing; or

5. other qualifying events which the commissioner shall approve for any particular filing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1505. Type of Product

A. Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to R.S. 22:161-181; 22:191-197; and the applicable portions of Part XIV, (22:611-672).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1507. Assignee/Beneficiary

A. Prior to the payment of the accelerated benefit, the insurer is required to obtain from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for payout. If the insurer making the accelerated benefit is itself the assignee under the policy, no such acknowledgment is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1509. Criteria for Payment

A. Lump Sum Settlement Option Required. Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.

B. Restrictions on Use of Proceeds. No restrictions are permitted on the use of the proceeds.

C. Accidental Death Benefit Provision. If any death benefit remains after payment of an accelerated benefit, the accidental death benefit provision, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1511. Disclosures

A. Descriptive Title. The terminology *accelerated benefit* shall be included in the descriptive title. Products regulated under this regulation shall not be described or marketed as long-term care insurance or as providing long-term care benefits.

B. Tax Consequences. A disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

C. Solicitations

1. A written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

a. In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgment of the disclosure shall be signed by the applicant and writing agent.

b. In the case of a solicitation by direct response methods, the insurer shall provide disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund shall be received if policy is returned to the company within the free look period.

c. In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificate holder.

2. If there is a premium or cost of insurance charge, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

a. In the case of agent solicited insurance, the agent shall provide the illustration to the applicant prior to or concurrently with the application.

b. In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered.

c. In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificate holder.

3. Disclosure of Premium Charge

a. Insurers with financing options other than as described in §1519.A.2 and 3 of this regulation shall disclose to the policy owner any premium or cost of insurance charge for the accelerated benefit. These insurers shall make a reasonable effort to assure that the certificate holder is aware of any additional premium or cost of insurance charge if the certificate holder is required to pay such charge.

b. Insurers shall furnish an actuarial demonstration to the state insurance department when filing the product disclosing the method of arriving at their cost for the accelerated benefit.

c. Disclosure of Administrative Expense Charge. The insurer shall disclose to the policy owner any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificate holder is aware of any administrative expense charge if the certificate holder is required to pay such charge.

D. Effect of the Benefit Payment. When a policy owner or certificate holder requests an acceleration, the insurer shall send a statement to the policy owner or certificate holder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. The statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policy owner or certificate holder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificate holder under a group policy to reflect any new, reduced in-force face amount of the contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1513. Effective Date of the Accelerated Benefits

A. The accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider. The accelerated benefit provision shall be effective for illness no more than 30 days following the effective date of the policy or rider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1515. Waiver of Premiums

A. The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the

benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1517. Discrimination

A. Insurers shall not unfairly discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy. Insurers shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1519. Actuarial Standards

A. Financing Options

1. The insurer may require a premium charge or cost of insurance charge for the accelerated benefit. These charges shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in the experience rating.

2. The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

a. the current yield on 90 day treasury bills; or

b. the current maximum statutory adjustable policy loan interest rate.

3. The insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

a. the current yield on 90 day treasury bills; or

b. the current maximum statutory adjustable policy loan interest rate. The interest rate accrued on the portion of the lien which is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

B. Effect on Cash Value

1. Except as provided in §1519.B.2, when an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.

2. Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest can be considered a lien against the death benefit of the policy or rider, and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans could also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

C. Effect of Any Outstanding Policy Loans on Accelerated Death Benefit Payment. When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1521. Actuarial Disclosure and Reserves

A. Actuarial Memorandum. A qualified actuary should describe the accelerated benefits, the risks, the expected costs and the calculation of statutory reserves in an actuarial memorandum accompanying each state filing. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.

B. Reserves

1. When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with the Standard Valuation Law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American Academy of Actuaries. Mortality tables and interest currently recognized for life insurance reserves by the NAIC may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary must follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover:

a. policies upon which no claim has yet arisen;

b. policies upon which an accelerated claim has arisen.

2. For policies and certificates which provide actuarially equivalent benefits, no additional reserves need to be established.

3. Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability such excess must be held as a non-admitted asset.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

§1523. Filing Requirement

A. The filing and prior approval of forms containing an accelerated benefit is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:644.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 18:1409 (December 1992).

Chapter 17. Regulation 45—Filing of Affirmative Action Plans

§1701. Purpose

A. The purpose of this regulation is to implement R.S. 22:1923.A.(l), which requires an insurer to file an affirmative action plan upon the violation of a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1703. Applicability and Scope

A. This regulation applies to any insurer that is called for hearing before the commissioner for violating Part X of the Insurance Code (Equal Opportunity In Insurance) and found to be in violation of a Cease and Desist Order issued in accordance with the provisions of R.S. 22:1923.A. It sets forth the minimum content and procedures for the filing of an affirmative action plan by an insurer who violates Part X of the Insurance Code, and who then violates a cease and desist order issued by the commissioner after hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1705. Content and Procedure

A. The commissioner shall notify an insurer of its violation of a cease and desist order issued pursuant to Part X of the Insurance Code by Certified U.S. Mail, return receipt requested. Said notification shall also direct the insurer to file an affirmative action plan.

B. The notice shall require the insurer to file its plan within 20 days of receipt of the notice.

C. The insurer shall file its plan by means of the U.S. Mail, and it shall contain the minimum requirements stated in R.S. 22:1923.C(4)(a) and (b).

D. The insurer shall address the plan to the attention of the Office of Minority Affairs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

§1707. Effective Date

A. This regulation shall become effective upon final promulgation in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1923.A.(1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1581 (December 1993).

Chapter 19. Regulation 46—Long-Term Care Insurance

§1901. Purpose

A. The purpose of this regulation is to implement R.S. 22:1731-1741, Long-Term Care Insurance Act, to promote the public interest; to promote the availability of long-term care insurance coverage; to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices; to facilitate public understanding and comparison of long-term care insurance coverages; and to facilitate flexibility and innovation in the development of long-term care insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005).

§1903. Applicability and Scope

A. Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered, or issued for delivery, in this state on or after February 20, 2005, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations; and all similar organizations to the extent they are authorized to issue life or health insurance. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted. Renewal policies shall comply with this regulation as amended.

B. Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. the benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

2. the disability income policy is advertised, marketed or offered as insurance for long-term care services; or

3. benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005).

§1905. Definitions

A. For the purpose of this regulation, the terms Applicant, Certificate, Commissioner, Group Long-Term Care Insurance, Long-Term Care Insurance, Policy, and Qualified Long-Term Care Insurance shall have the meanings set forth in R.S. 22:1734. In addition, the following definitions will apply.

Exceptional Increase—

a. only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

i. due to changes in laws or regulations applicable to long-term care coverage in this state; or

ii. due to increased and unexpected utilization that affects the majority of insurers of similar products;

b. except as provided in §1937, exceptional increases are subject to the same requirements as other premium rate schedule increases;

c. the commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase;

d. the commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Incidental (as used in §1937.J)—that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Qualified Actuary—a member in good standing of the American Academy of Actuaries.

Similar Policy Forms—all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in R.S. 22:1734(4)(a) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005).

§1907. Policy Definitions

A. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.

Activities of Daily Living—at least bathing, continence, dressing, eating, toileting, and transferring.

Acute Condition—that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

Adult Day Care—a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Bathing—washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Cognitive Impairment—a deficiency in a person's short or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Continence—the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing—putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating—feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.

Hands-On Assistance—physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

Home Health Care Services—medical and nonmedical services provided to ill, disabled, or infirmed persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

Medicare—"the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted, and any later amendments or substitutes thereof," or words of similar import.

Mental or Nervous Disorder—shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Personal Care—the provision of hands-on services to assist an individual with activities of daily living.

Skilled Nursing Care, Intermediate Care, Personal Care, Home Care and other services—shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

Toileting—getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring—moving into or out of a bed, chair, or wheelchair.

All providers of services including, but not limited to, *Skilled Nursing Facility, Extended Care Facility, Intermediate Care Facility, Convalescent Nursing Home, Personal Care Facility, and Home Care Agency*—shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), and 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:976 (August 1997).

§1909. Policy Practices and Provisions

A. Renewability. The terms *guaranteed renewable* and *noncancellable* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of §1913 of this regulation.

1. A policy issued to an individual shall not contain renewal provisions other than guaranteed renewable or noncancellable.

2. The term *guaranteed renewable* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term *noncancellable* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

4. The term *level premium* may only be used when the insurer does not have the right to change the premium.

5. In addition to the other requirements of §1909.A, a qualified long-term insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

1. preexisting conditions or diseases;

2. mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. alcoholism and drug addiction;

4. illness, treatment, or medical condition arising out of:

a. war or act of war (whether declared or undeclared);

b. participation in a felony, riot, or insurrection;

c. service in the armed forces or units auxiliary thereto;

d. suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

e. aviation (this exclusion applies only to non-fare paying passengers);

5. treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

6. expenses for services or items available or paid under another long-term care insurance or health insurance policy;

7. in the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

8. Subsection 1909.B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization, if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion

1. Group long-term care insurance issued in this state on or after the effective date of §1909 shall provide covered individuals with a basis for continuation or conversion of coverage.

2. For the purposes of §1909, a *basis for continuation of coverage* means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium, when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

3. For the purposes of §1909, a *basis for conversion of coverage* means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of §1909, *converted policy* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

5. Written application for the converted policy shall be made, and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

a. termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. the terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

i. providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

ii. the premium for which is calculated in a manner consistent with the requirements of §1909.D.6.

8. Notwithstanding any other provision of §1909, a converted policy issued to an individual who, at the time of conversion, is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of §1909, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of §1909, a *managed-care plan* is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

E. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and

2. shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

F.1. The premium charged to an insured shall not increase due to either:

a. the increasing age of the insured at ages beyond 65; or

b. the duration the insured has been covered under the policy.

2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under §1949, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under §1949, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

1. In the case of a group defined in R.S. 22:1734(4)(a), any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

a. the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

c. the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by applicable state or federal law, is maintained.

2. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer’s ability to confirm enrollment and coverage amounts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:462 (February 2005).

§1911. Unintentional Lapse

A. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following.

1. Notice before Lapse or Termination

a. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium or a written waiver, dated and signed by the applicant, electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

> "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

b. The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

c. When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in §1911.A.1.a need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

d. Lapse or Termination for Nonpayment of Premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to §1911.A.1.a, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

B. Reinstatement. In addition to the requirement in §1911.A.1, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured, if requested within five months after termination, and shall allow for the collection of past due premium where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:978 (August 1997), LR 31:464 (February 2005).

§1913. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

1. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

2. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made, in writing, by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to, in writing and signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider, or endorsement.

C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as *usual and customary*, *reasonable and customary* or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-Existing Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing post confinement, post-acute care, or recuperative benefits shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall clearly label such paragraph, "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider, and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. §1913.F shall not apply to qualified long-term care insurance contracts.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate provision and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this provision. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy, and in the outline of coverage as contained in §1955.F.3 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in §1955.F.3 that the policy is not intended to be a qualified long-term care insurance contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:978 (August 1997), LR 31:465 (February 2005).

§1915. Required Disclosure of Rating Practices to Consumers

A. This Section shall apply as follows.

1. Except as provided in §1915.A.2, §1915 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005.

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. 22:1734(4), which policy was in force at the time this amended regulation became effective, the provisions of §1915 shall apply on the policy anniversary following February 19, 2006.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in §1915.B to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that

time. In such a case, an insurer shall provide all of the information listed in §1915 to the applicant no later than at the time of delivery of the policy or certificate:

1. a statement that the policy may be subject to rate increases in the future;

2. an explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

3. the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

4. a general explanation for applying premium rate or rate schedule adjustments that shall include:

a. a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

b. the right to a revised premium rate or rate schedule as provided in §1915.B.3 if the premium rate or rate schedule is changed;

5.a. information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

i. the policy forms for which premium rates have been increased;

ii. the calendar years when the form was available for purchase; and

iii. the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

b. the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

c. an insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

d. if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of §1915 or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with §1915.B.5.a of this Paragraph;

e. if the acquiring insurer in §1915.B.5.d above files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in §1915.B.5.d, the acquiring insurer shall make all disclosures required by §1915.B.5, including disclosure of the earlier rate increase referenced in §1915.B.5.d.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under §1915.B.1 and 5. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of §1915.B and §1915.C of this Section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by §1915.B when the rate increase is implemented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:465 (February 2005).

§1917. Initial Filing Requirements

A. This Section applies to any long-term care policy issued in this state on or after August 19, 2005.

B. An insurer shall provide the information listed in §1917.B to the commissioner 45 days prior to making a long-term care insurance form available for sale:

1. a copy of the disclosure documents required in §1915; and

2. an actuarial certification consisting of at least the following:

a. a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

b. a statement that the policy design and coverage provided have been reviewed and taken into consideration;

c. a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

d. a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

i. sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

ii. a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

iii. a statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

iv. a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur:

(a). an aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(b). if the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under §1917.C based on a standard age distribution; and

e.i. a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

ii. a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

C.1. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

2. In the event the commissioner asks for additional information under this provision, the period in §1917.B does not include the period during which the insurer is preparing the requested information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:466 (February 2005).

§1919. Requirements to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

2. guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status, so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

3. covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in §1919.A shall be made to the group policyholder; except, if the policy is issued to a group defined in R.S. 22:1734(4)(d), other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in §1919.A shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D.1. Insurers shall include the following information in or with the outline of coverage:

a. a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period;

b. any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

2. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

E. Inflation protection benefit increases, under a policy which contains such benefits, shall continue without regard to an insured's age, claim status, or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose, in a conspicuous manner, that the premium may change in the future, unless the premium is guaranteed to remain constant.

G.1. Inflation protection, as provided in §1919.A.1, shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection, signed by the policyholder, as required in §1919.G.1. The rejection may be either in the application or on a separate form.

2. The rejection shall be considered a part of the application and shall state:

> I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1156 (September 1993), amended LR 23:975 (August 1997), LR 31:467 (February 2005).

§1921. Prohibition against Post-Claim Underwriting (former §1915)

A. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B.1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

1. the following language shall be set out conspicuously, and in close conjunction with the applicant's signature block, on an application for a long-term care insurance policy or certificate:

> CAUTION: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy;

2. the following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

> CAUTION: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address];

3. prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

a. a report of a physical examination;

b. an assessment of functional capacity;

c. an attending physician's statement; or

d. copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated, and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in §1961, Appendix A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:467 (February 2005).

§1923. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies (former §1917)

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

1. by requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

2. by requiring that the insured or claimant first, or simultaneously, receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

3. by limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. by excluding coverage for personal care services provided by a home health aide;

6. by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7. by requiring that the insured or claimant have an acute condition before home health care services are covered;

8. by limiting benefits to services provided by Medicare-certified agencies or providers;

9. by excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1158 (September 1993), amended LR 23:982 (August 1997), repromulgated LR 31:467 (February 2005).

§1925. Requirements for Application Forms and Replacement Coverage (former §1921)

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by R.S. 22:1734(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

   a. If so, with which company?

   b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

B. Producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five years which are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner.

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT
AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER
[BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Producer, Broker or Other Representative)
[Typed Name and Address of Producer or Broker]

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Applicant's Signature) (Date)

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care

coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address, including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life Insurance policies that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Regulation 70. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:468 (February 2005).

§1927. Reporting Requirements (former §1923)

A. Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percentage of the producer's total annual sales.

B. Each insurer shall report annually, by June 30, the 10 percent of its producers with the greatest percentages of lapses and replacements, as measured by §1927.A (§1961, Appendix G).

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually, by June 30, the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year (§1961, Appendix G).

E. Every insurer shall report annually, by June 30, the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year (§1961, Appendix G).

F. Every insurer shall report annually, by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (§1961, Appendix E).

G. For purposes of §1927:

1. *policy* means only long-term care insurance; and

2. subject to §1927.G.3, *claim* means a request for a 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;

3. *denied* means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. *report* means on a statewide basis.

H. Reports required under this Section shall be filed with the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:469 (February 2005).

§1929. Licensing (former §1925)

A. A producer is not authorized to market, sell, solicit, or negotiate with respect to long-term care except as authorized by R.S. 22:1133 and R.S. 22:1137(A)(1) and (2).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005).

§1931. Discretionary Powers of Commissioner (former §1927)

A. The commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. the modification or suspension would be in the best interest of the insureds;

2. the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

3.a. the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

b. the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

c. the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005).

§1933. Reserve Standards (former §1929)

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with R.S. 22:162, R.S. 22:162.1. and R.S. 22:163. Claim reserves shall also be established in the case when the policy or rider is in claim status.

B. Reserves for policies and riders subject to §1933.B should be based on the multiple decrement model, utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit, assuming no long-term care benefit.

C.1. In the development and calculation of reserves for policies and riders subject to §1933.C, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs including, but not limited to, the following:

a. definition of insured events;

b. covered long-term care facilities;

c. existence of home convalescence care coverage;

d. definition of facilities;

e. existence or absence of barriers to eligibility;

f. premium waiver provision;

g. renewability;

h. ability to raise premiums;

i. marketing method;

j. underwriting procedures;

k. claims adjustment procedures;

l. waiting period;

m. maximum benefit;

n. availability of eligible facilities;

o. margins in claim costs;

p. optional nature of benefit;

q. delay in eligibility for benefit;

r. inflation protection provisions; and

s. guaranteed insurability option.

2. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

D. When long-term care benefits are provided other than as in §1933.A, reserves shall be determined in accordance with prevailing NAIC actuarial standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005).

§1935. Loss Ratio (former §1931)

A. This Section shall apply to all long-term care insurance policies or certificates except those covered under §1917 and §1937.

B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums, provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. statistical credibility of incurred claims experience and earned premiums;

2. the period for which rates are computed to provide coverage;

3. experienced and projected trends;

4. concentration of experience within early policy duration;

5. expected claim fluctuation;

6. experience refunds, adjustments, or dividends;

7. renewability features;

8. all appropriate expense factors;

9. interest;

10. experimental nature of the coverage;

11. policy reserves;

12. mix of business by risk classification; and

13. product features such as long elimination periods, high deductibles, and high maximum limits.

C. Section 1935.B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

1. the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of R.S. 22:168;

3. the policy meets the disclosure requirements of R.S. 22:1736(H), (I) and (J);

4. any policy illustration that meets the applicable requirements of Regulation 55; and

5. an actuarial memorandum is filed with the insurance department that includes:

a. a description of the basis on which the long-term care rates were determined;

b. a description of the basis for the reserves;

c. a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. the estimated average annual premium per policy and the average issue age;

g. a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:470 (February 2005).

§1937. Premium Rate Schedule Increases

A. This Section shall apply as follows.

1. Except as provided in §1937.A.2, §1937 applies to any long-term care policy or certificate issued in this state on or after August 19, 2005.

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in R.S. 22:1734(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1937 shall apply on the policy anniversary following February 19, 2006.

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 45 days prior to the notice to the policyholders and shall include:

1. information required by §1915;

2. certification by a qualified actuary that:

a. if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

b. the premium rate filing is in compliance with the provisions of §1937;

3. an actuarial memorandum justifying the rate schedule change request that includes:

a. lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

i. annual values for the five years preceding and the three years following the valuation date shall be provided separately;

ii. the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

iii. the projections shall demonstrate compliance with §1937.C; and

iv. for exceptional increases:

(a). the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(b). in the event the commissioner determines as provided in §1905.A.4 that offsets may exist, the insurer shall use appropriate net projected experience;

b. disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

d. a statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

e. in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

4. a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

5. sufficient information for review and approval of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

2. premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. the accumulated value of the initial earned premium times 58 percent;

b. 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

c. the present value of future projected initial earned premiums times 58 percent; and

d. 85 percent of the present value of future projected premiums not in §1937.C.2.c on an earned basis;

3. in the event that a policy form has both exceptional and other increases, the values in §1937.C.2.b and d will also include 70 percent for exceptional rate increase amounts; and

4. all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as defined annually under R.S. 22:163. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in §1937.B.3.a, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in §1937.K, the projections required by §1937.D shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in §1937.B.3.a, shall be filed for approval by the commissioner every five years following the end of the required period in §1937.D. For group insurance policies that meet the conditions in §1937.K, the projections required by §1937.E shall be provided to the policyholder in lieu of filing with the commissioner.

F.1. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in §1937.C, the commissioner may require the insurer to implement any of the following:

a. premium rate schedule adjustments; or

b. other measures to reduce the difference between the projected and actual experience.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to §1937.B.3.e, if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

1. a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in §1937.H; and

2. the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to §1937.C had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in §1937.C.2.a and c.

H.1. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

a. the rate increase is not the first rate increase requested for the specific policy form or forms;

b. the rate increase is not an exceptional increase; and

c. the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

a. The offer shall:

i. be subject to the approval of the commissioner;

ii. be based on actuarially sound principles, but not be based on attained age; and

iii. provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

i. the maximum rate increase determined based on the combined experience; and

ii. the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of §1937.H of this Section, prohibit the insurer from either of the following:

1. filing and marketing comparable coverage for a period of up to five years; or

2. offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Section 1937.A through I shall not apply to policies for which the long-term care benefits provided by the policy are *incidental*, as defined in §1905.B, if the policy complies with all of the following provisions:

1. the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. R.S. 22:168;

b. R.S. 22:173.1; and

c. R.S. 22:1500;

3. the policy meets the disclosure requirements of R.S. 22:1736(H), (I), and (J);

4. the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

a. policy illustrations as required by Regulation 55;

b. disclosure requirements in Regulation 28;

5. an actuarial memorandum is filed with the insurance department that includes:

a. a description of the basis on which the long-term care rates were determined;

b. a description of the basis for the reserves;

c. a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. the estimated average annual premium per policy and the average issue age;

g. a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Sections 1937.F and 1937.H shall not apply to group insurance policies as defined in R.S. 22:1734(4)(a) where:

1. the policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

2. the policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:471 (February 2005).

§1939. Filing Requirement (former §1933)

A. Prior to a long-term care insurer or other similar organization offering group long-term care insurance to a resident of this state, pursuant to R.S. 22:1735, it shall file with the commissioner evidence that the group meets the requirements of R.S. 22:1734(4)(d); and such insurers shall file for approval any group policy or certificate to be offered to residents of this state, regardless of from where it was issued or delivered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:473 (February 2005).

§1941. Filing Requirements for Advertising (former §1935)

A. Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio, or television medium, to the commissioner of insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:473 (February 2005).

§1943. Standards for Marketing (former §1937)

A. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. establish marketing procedures and producer training requirements to assure that:

a. any marketing activities, including any comparison of policies by its producers or other producers will be fair and accurate; and

b. excessive insurance is not sold or issued;

2. display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

> Notice to Buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

3. provide copies of the disclosure forms required in §1915.C (Appendices B and F) to the applicant;

4. inquire, and otherwise make every reasonable effort to identify, whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness, or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

5. establish auditable procedures for verifying compliance with §1943.A;

6. if the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program, approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that such a program is available and the name, address and telephone number of the program;

7. for long-term care health insurance policies and certificates, use the terms *noncancellable* or *level premium* only when the policy or certificate conforms to §1909.A.3 of this regulation;

8. provide an explanation of contingent benefit upon lapse provided in §1949.D.3.

B. In addition to the practices prohibited in R.S. 22:1211 et seq., the following acts and practices are prohibited.

Cold Lead Advertising—making use directly, or indirectly, of any method of marketing which fails to disclose, in a conspicuous manner, that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

High Pressure Tactics—employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

Misrepresentation—misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

Twisting—knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

C.1. With respect to the obligations set forth in §1943.C.1, the primary responsibility of an association, as defined in R.S. 22:1734(4)(b), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues, in general, so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

2. The insurer shall file with the insurance department the following material:

a. the policy and certificate;

b. a corresponding outline of coverage; and

c. all advertisements requested by the insurance department.

3. The association shall disclose in any long-term care insurance solicitation:

a. the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

b. a brief description of the process under which the policies, and the insurer issuing the policies, were selected.

4. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

5. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

6.a. The association shall also:

i. at the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

ii. actively monitor the marketing efforts of the insurer and its producers; and

iii. review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

b. Section 1943.C.6.a.i.-iii shall not apply to qualified long-term care insurance contracts.

7. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in §1943.C.

8. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in §1943.C.

9. Failure to comply with the filing and certification requirements of §1943 constitutes an unfair trade practice in violation of R.S. 22:1211 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:473 (February 2005).

§1945. Suitability (former §1939)

A. Section 1945 shall not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer, health care service plan, or other entity marketing long-term care insurance (the *issuer*) shall:

1. develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

2. train its producers in the use of its suitability standards; and

3. maintain a copy of its suitability standards and make them available for inspection, upon request, by the commissioner.

C.1. To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:

a. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

2. The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in §1945.C.1. The efforts shall include presentation to the applicant at, or prior to, application the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

3. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in §1961, Appendix B, is prohibited.

D. The issuer shall use the suitability standards it has developed, pursuant to §1945, in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in §1961, Appendix C, in not less than 12-point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to §1961, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005).

§1947. Prohibition against Pre-Existing Conditions and Probationary Periods in Replacement Policies or Certificates (former §1941)

A. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new long-term care policy for similar benefits, to the extent that similar exclusions have been satisfied under the original policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:475 (February 2005).

§1949. Nonforfeiture Benefit Requirement (former §1943)

A. Section 1949 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of R.S. 22:1738:

1. a policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in §1949.E; and

2. the offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under R.S. 22:1738 is rejected, the insurer shall provide the contingent benefit upon lapse described in §1949.

D.1. After rejection of the offer required under R.S. 22:1738, for individual and group policies without nonforfeiture benefits issued after the effective date of §1949, the insurer shall provide a contingent benefit upon lapse.

2. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

3. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. On or before the effective date of a substantial premium increase as defined in §1949.D.3, the insurer shall:

a. offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

b. offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of §1949.E. This option may be elected at any time during the 120-day period referenced in §1949.D.3; and

c. notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in §1949.D.3 shall be deemed to be the election of the offer to convert in §1949.D.4.b above.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in §1949.E.

1. For purposes of §1949, *attained age rating* is defined as a schedule of premiums, starting from the issue date, which increases with increasing age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

2. For purposes of §1949, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in §1949.E.3.

3. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of §1949.F.

4.a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

b. Notwithstanding §1949.E.4.a, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

i. the end of the tenth year following the policy or certificate issue date; or

ii. the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

G. There shall be no difference in the minimum nonforfeiture benefits, as required under §1949, for group and individual policies.

H. The requirements set forth in §1949 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in §1949.H.2, the provisions of §1949 apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

2. For certificates issued on or after the effective date of §1949, under a group long-term care insurance policy, as defined in R.S. 22:1734(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of §1949 shall not apply.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a continuing benefit on lapse shall be subject to the loss ratio requirements of §1935 treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under §1949.D.3, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. the nonforfeiture provision shall be appropriately captioned;

2. the nonforfeiture provision shall provide that the amount of the benefit available in the event of a default in the payment of any premiums, and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest, as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

3. the nonforfeiture provision shall provide at least one of the following:

a. reduced paid-up insurance;

b. extended term insurance;

c. shortened benefit period; or

d. other similar offerings approved by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:475 (February 2005).

§1951. Standards for Benefit Triggers (former §1945)

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

B.1. Activities of daily living shall include at least the following as defined in §1907 and in the policy:

a. bathing;

b. continence;

c. dressing;

d. eating;

e. toileting; and

f. transferring.

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in §1951.B.1, as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in §1951.A-B.

D. For purposes of §1951, the determination of a deficiency shall not be more restrictive than:

1. requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2. if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in §1951 shall be effective January 1, 1999 and shall apply as follows.

1. Except as provided in §1951.G.2, the provisions of §1951 apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

2. For certificates issued on or after the effective date of §1951, under a group long-term care insurance policy, as defined in R.S. 22:1734(4)(a) that was in force at the time this amended regulation became effective, the provisions of §1951 shall not apply.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), repromulgated LR 31:477 (February 2005).

§1953. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts (former §1947)

A. For purposes of this Section the following definitions apply.

1. Qualified long-term care services means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2.a. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

i. being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

ii. requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

b. The term *chronically ill individual* shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

3. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the secretary of the treasury.

4. Maintenance or personal care services means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

B. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to §1953.C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

E. Certifications required pursuant to §1953.C may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

F. Qualified long-term care contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:477 (February 2005).

§1955. Standard Format Outline of Coverage (former §1949)

A. Section 1955 of the regulation implements, interprets, and makes specific the provisions of R.S. 22:1736(G) in prescribing a standard format and the content of an outline of coverage.

B. The outline of coverage shall be a free-standing document, using no smaller than 10-point type.

C. The outline of coverage shall contain no material of an advertising nature.

D. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

E. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

F. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS—CITY AND STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

CAUTION: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. **PURPOSE OF OUTLINE OF COVERAGE**. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of

coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

3. **FEDERAL TAX CONSEQUENCES.**

(a) This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

(b) Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED**.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE**. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [company name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY**.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE**. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [company name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions;]

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**

(a) [Provide a brief description of the right to return—"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* available from the insurance company.

(a) [For producers] Neither [insert company name] nor its producers represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage 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, such as in a nursing home, in the community or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. **BENEFITS PROVIDED BY THIS POLICY.**

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. **LIMITATIONS AND EXCLUSIONS.**

[Describe:

(a) Pre-existing conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This Section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. **PREMIUM.**

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. **ADDITIONAL FEATURES.**

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:478 (February 2005).

§1957. Requirement to Deliver Shopper's Guide (former §1951)

A. A long-term care insurance shopper's guide in the format developed by the NAIC, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

1. In the case of producer solicitations, a producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under R.S. 22:1736(I).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:480 (February 2005).

§1959. Penalties (former §1953)

A. In addition to any other penalties provided by the 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 $10,000, whichever is greater.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 19:1153 (September 1993), amended LR 23:975 (August 1997), LR 31:480 (February 2005).

§1961. Appendices (former §1955)

A. Appendix A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF LOUISIANA
FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form Number	Policy and Certificate Number	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

_____

_____

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

B. Appendix B

LONG-TERM CARE INSURANCE
PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their

family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

PREMIUM INFORMATION

Policy Form Numbers _____

The premium for the coverage you are considering will be [$ _____per month, or $_____ per year.] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premiums?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

What is your annual income? (check one)

☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000]

☐ $[30-50,000] ☐ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7 percent of your income.

Will you buy inflation protection? (check one) ☐ **Yes** ☐ **No**

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering?

Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐	The answers to the questions above describe my financial situation. **or** I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future**. (This box must be checked).

Signed:_____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed:_____ _____
(Producer) (Date)

Producer's Printed Name:_____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:_____ _____]
(Applicant) (Date)

The company may contact you to verify your answers.

C. Appendix C

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance
- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare
- Medicare does **not** pay for most long-term care.

Medicaid
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

D. Appendix D

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

□ Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

□ No. I have decided not to buy a policy at this time.

_____ _____

Applicant Signature Date

Please return to [issuer] at [address] by [date].

E. Appendix E

CLAIMS DENIAL REPORTING FORM
LONG-TERM CARE INSURANCE

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____

_____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number:_____

Line of Business: _____Individual _____Group _____

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

F. Appendix F

Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

LONG-TERM CARE INSURANCE
POTENTIAL RATE INCREASE DISCLOSURE FORM

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____])
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

G. Appendix G

LONG-TERM CARE INSURANCE
REPLACEMENT AND LAPSE REPORTING FORM

For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____ Company NAIC Number: _____

Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each producer on that producer's amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Producers with the Greatest Percentage of Replacements

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Replaced By This Producer	Number of Replacements As % of Number Sold By This Producer

Listing of the 10% of Producers with the Greatest Percentage of Lapses

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Lapsed By This Producer	Number of Lapses As % of Number Sold By This Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales ____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1736(A), 22:1736(E), 22:1738(C), 22:1739, and 22:1740.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:480 (February 2005).

Chapter 21. Regulation 47—Actuarial Opinion and Memorandum Regulation

§2101. Purpose

A. The purpose of this regulation is to prescribe:

1. requirements for statements of actuarial opinion that are to be submitted in accordance with R.S. 22:162.1, and for memoranda in support thereof;

2. rules applicable to the appointment of an appointed actuary; and

3. guidance as to the meaning of "adequacy of reserves."

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§2103. Authority

A. This regulation is issued pursuant to the authority vested in the commissioner of insurance of the State of Louisiana under R.S. 22:162.1. This regulation will take effect for annual statements for the year 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§2105. Scope

A. This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this state and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this state. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify methods of actuarial analysis particular to a company's business profile and may include specific actuarial methods and assumptions including, where appropriate, simplified actuarial methods and assumptions, when, in the commissioner's judgment, such specifications are necessary, or sufficient, to meet the objective of rendering an acceptable opinion as to the adequacy of the reserves and related items.

B. This regulation shall be applicable to all annual statements filed with the office of the commissioner after the effective date of this regulation. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §2111 of this regulation, and a memorandum in support thereof in accordance with §2113 of this regulation, shall be required each year.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§2107. Definitions

Actuarial Opinion—the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §2111 of this regulation and with applicable Actuarial Standards of Practice.

Actuarial Standards Board—the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

Annual Statement—that statement required by Section R.S. 22:1451 of the Insurance Law to be filed by the company with the office of the commissioner annually.

Appointed Actuary—an individual who is appointed or retained in accordance with the requirements set forth in §2109.C. of this regulation to provide the actuarial opinion and supporting memorandum as required by R.S. 22:162.1.

Asset Adequacy Analysis—an analysis that meets the standards and other requirements referred to in §2109.D. of this regulation.

Commissioner—the insurance commissioner of this state.

Company—a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this regulation.

Qualified Actuary—an individual who meets the requirements set forth in §2109.B. of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2544 (October 2005).

§2109. General Requirements

A. Submission of Statement of Actuarial Opinion

1. There is to be included on or attached to Page 1 of the annual statement for each year beginning with the year in which this regulation becomes effective the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with §2111 of this regulation.

2. Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

B. Qualified Actuary. A "qualified actuary" is an individual who:

1. is a member in good standing of the American Academy of Actuaries;

2. is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

3. is familiar with the valuation requirements applicable to life and health insurance companies;

4. has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

a. violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as a qualified actuary;

b. been found guilty of fraudulent or dishonest practices;

c. demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

d. submitted to the commissioner during the past five years, pursuant to this regulation, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or

e. resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

5. has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under Paragraph 4 above.

C. Appointed Actuary. An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this regulation, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in Subsection B. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in Subsection B. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

D. Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this regulation:

1. shall conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and on any additional standards under this regulation, which standards are to form the basis of the statement of actuarial opinion in accordance with this regulation; and

2. shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board;

3. shall comply with the commissioner's specific method of actuarial analysis when the commissioner has specified a method of actuarial analysis to be in effect for a particular company. When a conflict exists between a commissioner specified method of actuarial analysis and the standards of Paragraphs 1 and 2, the commissioner's specific method of actuarial analysis prevails.

E. Liabilities to be Covered

1. Under authority of R.S. 22:162.1, the statement of actuarial opinion shall apply to all in force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of Exhibits 5, 6 and 7, and claim liabilities in Exhibit 8, Part 1 and equivalent items in the separate account statement or statements.

2. If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in the Standard Valuation Law, the company shall establish the additional reserve.

3. Additional reserves established under Paragraph 2 above and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2544 (October 2005).

§2111. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis

A. General Description. The statement of actuarial opinion submitted in accordance with this Section shall consist of:

1. a paragraph identifying the appointed actuary and his or her qualifications (see Paragraph B.1);

2. a scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, (see Paragraph B.2) and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

3. a reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see Paragraph B.3), supported by a statement of each such expert in the form prescribed by Subsection E; and

4. an opinion paragraph expressing the appointed actuary’s opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Paragraph B.6);

5. one or more additional paragraphs will be needed in individual company cases as follows:

a. if the appointed actuary considers it necessary to state a qualification of his or her opinion;

b. if the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

c. if the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release;

d. if the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

B. Recommended Language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances should be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this Section.

1. The opening paragraph should generally indicate the appointed actuary's relationship to the company and his or her qualifications to sign the opinion.

a. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

> "I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said insurer to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

b. For a consulting actuary, the opening paragraph should include a statement such as:

> "I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

2. The scope paragraph should include a statement such as:

> "I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20[ ]. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis."

Asset Adequacy Tested Amounts—Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+ (3) (4)
Exhibit 5 A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability - Active					
F Disability - Disabled					
G Miscellaneous					
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6 A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 6 Item 2, Page 3)					
Exhibit 7 Premium and Other Deposit Funds (Column 5, Line 14)					

Asset Adequacy Tested Amounts—Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+ (3) (4)
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities Certain (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 7 (Column 1, Line 14)					
Exhibit 8, Part 1 1 Life (Page 3, Line 4.1)					
2 Health (Page 3 Line 4.2)					
Total Exhibit 11, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					

IMR (General Account, Page ___ Line ___)	
(Separate Accounts, Page ___ Line ___)	
AVR (Page ___ Line ___)	(c)
Net Deferred and Uncollected Premium	

Notes:

a. The additional actuarial reserves are the reserves established under Paragraph 2 of Section 2109.E.

b. The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Section 2109.D of this regulation, by means of symbols that should be defined in footnotes to the table.

c. Allocated amount of Asset Valuation Reserve (AVR).

3. If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

> "I have relied on [name], [title] for [e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"], as certified in the attached statement. I have reviewed the information relied upon for reasonableness."
>
> A statement of reliance on other experts should be accompanied by a statement by each of the experts in the form prescribed by §2111.E.

4. If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

> "My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

5. If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

> "In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying in force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."
>
> The section shall be accompanied by a statement by each person relied upon in the form prescribed by Subsection E.

6. The opinion paragraph should include a statement such as:

> "In my opinion the reserves and related actuarial values concerning the statement items identified above:
>
> a. are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;
>
> b. are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;
>
> c. meet the requirements of the Insurance Law and Regulation of the state of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;
>
> d. are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and
>
> e. include provision for all actuarial reserves and related statement items which ought to be established.
>
> The reserves and related items, when considered in light of the assets held by the company with respect to such 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, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the commissioner, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)
>
> The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.
>
> This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.
>
> or

The following material changes which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

Note: Choose one of the above two paragraphs, whichever is applicable.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company' future experience may not follow all the assumptions used in the analysis.

_____
Signature of Appointed Actuary

_____
Address of Appointed Actuary

_____
Telephone Number of Appointed Actuary

_____
Date"

C. Assumptions for New Issues

1. The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this §2111.

D. Adverse Opinions

1. If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

E. Reliance on Information Furnished by Other Persons

1. If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

F. Alternate Option

1. The commissioner may provide an alternative filing option for domestic insurance companies that allows for the reparation of an alternative form of opinion. The commissioner shall provide specific criteria for such an alternative filing option and instructions for the associated testing and documentation.

2. The Standard Valuation Law gives the commissioner broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of Subsection B.6.(a)(iii), the commissioner may make one or more of the following additional approaches available to the opining actuary.

a. A statement that the reserves "meet the requirements of the insurance laws and regulations of the state of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the commissioner chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

b. Statement that the reserves "meet the requirements of the insurance laws and regulations of the state of [state of domicile] and I have verified that the company’s request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request have been met." If the commissioner chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. It shall remain valid until rescinded or modified by the commissioner. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request shall be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

c. A statement that the reserves "meet the requirements of the insurance laws and regulations of the state of [state of domicile] and I have submitted the required comparison as specified by this state."

i. If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in Clause ii below) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

ii. If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under NAIC codification standards. Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and

assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall be at least:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

iii. The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative.

iv. If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

v. The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

3. Notwithstanding the above, the commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within 60 days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract an independent actuary at the company's expense to prepare and file the opinion.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2545 (October 2005).

§2113. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary

A. General

1. In accordance with R.S. 22:162.1, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the commissioner.

2. In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of §2109.B of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

3. If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the actuarial standards board or the standards and requirements of this regulation, the commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the commissioner.

4. The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three years.

5. In accordance with R.S. 22:162.1, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection C. The regulatory asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

B. Details of the Memorandum Section Documenting Asset Adequacy Analysis

1. When the opinion provided under the domestic company alternative filing option as referred to in §2111.F.1, then an alternative memorandum shall be prepared in accordance with specific instructions of the commissioner and the company shall be exempt from the requirements of §2113, otherwise, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in §2109.D of this regulation and any additional standards under this regulation. It shall specify:

a. for reserves:

i. product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

ii. source of liability in force;

iii. reserve method and basis;

iv. investment reserves;

v. reinsurance arrangements;

vi. identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

vii. documentation of assumptions to test reserves for the following:

(a). lapse rates (both base and excess);

(b). interest crediting rate strategy;

(c). mortality;

(d). policyholder dividend strategy;

(e). competitor or market interest rate;

(f). annuitization rates;

(g). commissions and expenses; and

(h). morbidity;

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

2. for assets:

a. portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

b. investment and disinvestment assumptions;

c. source of asset data;

d. asset valuation bases; and

e. documentation of assumptions made for:

i. default costs;

ii. bond call function;

iii. mortgage prepayment function;

iv. determining market value for assets sold due to disinvestment strategy; and

v. determining yield on assets acquired through the investment strategy;

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

3. for the analysis basis:

a. methodology;

b. rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

c. rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

d. criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

e. whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

4. summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

5. summary of results; and

6. conclusions.

C. Details of the Regulatory Asset Adequacy Issues Summary

1. The regulatory asset adequacy issues summary shall include:

a. descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force;

b. the extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

c. the amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

d. comments on any interim results that may be of significant concern to the appointed actuary;

e. the methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and

f. whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

2. The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

D. Conformity to Standards of Practice. The memorandum shall include a statement:

> "Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

E. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve

1. An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

2. The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

F. Documentation. The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2548 (October 2005).

Chapter 23. Regulation 48—Standardized Claims Forms

§2301. Purpose

A. The purpose of this regulation is to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized and increase efficiency in the reimbursement of health care through standardization.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2303. Definitions

CDT-1 Codes—the current dental terminology prescribed by the American Dental Association.

CPT-4 Codes—the current procedural terminology published by the American Medical Association.

HCFA—the Federal Health Care Financing Administration of the U.S. Department of Health and Human Services.

HCFA for UB92—the health insurance claim form published by HCFA for use by institutional care providers.

HCFA Form 1500—the health insurance claim form published by HCFA for use by health care providers.

HCPCS—HCFA's common procedure coding system which is based upon the AMA's *Physician Current Procedural Terminology, Fourth Edition* (CPT-4).

1. *HCPCS Level I Codes*—the AMA's CPT-4 codes with the exception of anesthesiology services.

2. *HCPCS Level 2 Codes*—the codes for physician and nonphysician services are not included in COT-4.

Health Care Provider—

1. an acupuncturist licensed under R.S. 37:1356-1360;

2. a certified registered nurse anesthetist licensed under R.S. 37:930;

3. a chiropractor licensed under R.S. 37:2801-2830.7;

4. a dentist licensed under R.S. 37:751-794;

5. a dietician and nutritionist licensed under R.S. 37:3081-3093 and 36:259U;

6. durable medical equipment suppliers;

7. an emergency medical technician licensed under R.S. 40:1231-1232;

8. a general health clinic (excluding early periodic screening diagnosis treatment clinics) certified by the Louisiana Department of Health and Hospitals;

9. a hearing aid dealer licensed under R.S. 37:2441-2465;

10. a licensed practical nurse licensed under R.S. 37:961;

11. a mental health counselor licensed under R.S. 37:1101-1115;

12. a mental health clinic licensed under R.S. 28:567;

13. a midwife licensed under R.S. 37:3240-3257;

14. an occupational therapist licensed under R.S. 37:3001-3014;

15. an optometrist licensed under R.S. 37:1052;

16. a physical therapist and physical therapist assistant licensed under R.S. 37:2401-2419;

17. a physician licensed under R.S. 37:1261-1292;

18. a physician assistant licensed under R.S. 37:1360.21-27;

19. a podiatrist licensed under R.S. 37:611-628;

20. a psychologist licensed under R.S. 37:2351-2370;

21. a registered nurse licensed under R.S. 37:911-931;

22. a rehabilitation center licensed under 42:CFR 405.1701Q;

23. a respiratory therapist licensed under R.S. 37:3351-3361;

24. a social worker licensed under R.S. 37:2701-2718;

25. a speech pathologist and audiologist licensed under R.S. 2651-2665;

26. a substance abuse counselor licensed under R.S. 37:3371-3384;

27. a substance abuse prevention/treatment program licensed under R.S. 40:1058.1-1058.3;

28. a free standing ambulatory surgical center licensed under R.S. 40:2131-2141;

29. any other health care providers as licensed by the state of Louisiana;

ICD-9-CM Codes—the disease codes in the *International Classification of Diseases, Ninth Revision,* clinical modifications published by the U.S. Department of Health and Human Services.

Institutional Care Provider—

1. an adult day health care provider licensed under R.S. 46:1971-1980;

2. an ambulatory surgical center licensed under R.S. 40:2131-2143;

3. a drug screening laboratory licensed under R.S. 49:1111-1113, 1115-1118, 1121, 1122, and 1125;

4. an end stage renal dialysis facility under 42:CFR 405.2100;

5. a home health agency licensed under R.S. 40:2009.31-2009.40;

6. a hospice licensed under R.S. 40:2181-2191;

7. a hospital licensed under R.S. 40:2100-2114;

8. a nursing home licensed under R.S. 40:2009;

9. a residential care/community group home or residential facility licensed under R.S. 46:51, 1401-1411, and 28:1-284;

10. any other institutional care provider as licensed by the state of Louisiana.

J512 Form—the uniform dental claim form approved by the American Dental Association for use by dentists.

Medicaid—Title XIX of the Federal Social Security Act.

Medicare—Title XVIll of the Federal Social Security Act.

Revenue Codes—the codes established for use by institutional care providers by the National Uniform Billing Committee.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2305. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all issuers of health care policies or contracts of insurance, administrators of self-funded employee benefit plans, and other forms of insurance and entitlement programs under Title XVIII and Title XIX involved in the reimbursement of health care expenses, and all providers of health care licensed by the state.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2307. Requirements for Use of HCFA Form 1500

A. Health care providers, other than dentists, shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when billing patients or their representatives for reimbursement of claims with insurers for professional services.

B. An issuer may not require a health care provider to use any coding system for the initial filing of claims for health care services other than the following:

1. HCPCS Codes; and

2. ICD-9-CM Codes.

C. An issuer may not require a health care provider to use any other descriptor with a code or to furnish additional information with the initial submission of a HCFA Form 1500 except under the following circumstances:

1. when the procedure code used describes a treatment or service which has not been included in CPT-4 or is billed under an unlisted procedure code and a description of services is necessary; or

2. when the procedure code is followed by the CPT-4 modifier 22, 47, 50, 51, 52, 62, 66, 77, or 99; or

3. when required by a contract/agreement between the issuer and health care provider; or

4. as otherwise required by federal regulation; or

5. as otherwise required by the Office of Workers' Compensation of the Louisiana Department of Labor.

D. Use of HCFA Form 1500 shall be effective July 1, 1994 for all issuers excluding rehabilitation facilities reimbursed by Louisiana Medicaid which will have an effective date of January 1, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2309. Requirements for Use of HCFA Approved Form UB92

A. Institutional care providers shall use the HCFA approved Form UB92 and instructions provided by HCFA for use of the HCFA approved UB92 when billing patients or

their representatives directly and filing claims with issuers for professional services.

B. An issuer may not require an institutional care provider to use any coding system for the initial filing of claims for health care services other than the following:

1. ICD-9-CM Codes;

2. Revenue Codes;

3. HCPCS Level I Codes;

4. HCPCS Level 2 Codes; and

5. if charges include direct service of a health care provider, the information outlined in §2307 of this regulation.

C. Use of the HCFA approved Form UB92 shall be effective July 1, 1994 for all issuers excluding nursing facilities, adult day health care facilities, and residential care facilities reimbursed by Louisiana Medicaid which shall have an effective date of January 1, 1996.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2311. Requirements for Use of J512 Form

A. A dentist shall use the J512 Form and instructions provided by the American Dental Association CDT-1 for use of the J512 Form by billing patients or their representatives directly and filing claims with issuers for professional services.

B. An issuer may not require a dentist to use any other code other than the CDT-1 codes for the initial filing of claims for dental care services.

C. Use of J512 Form shall be effective July 1, 1994 for all issuers excluding reimbursement to dentists reimbursed by Louisiana Medicaid which shall have an effective date of January 1, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2313. General Provisions

A. A health care provider or institutional care provider shall file a claim in a manner consistent with the requirements of this regulation which are:

1. a paper form printed on 8.5-inch paper;

2. an electronically transmitted claim.

B. An issuer shall accept a form which is submitted in compliance with this regulation for the processing of the insured's or beneficiaries' claims.

C. Nothing in this regulation shall prevent an issuer from requesting additional information which is not contained on the forms required under this regulation to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant.

D. All health care providers and institutional care providers shall:

1. use the most current editions of the HCFA approved Form 1500, HCFA Form UB92, or J512 Form and most current instructions for these forms in the billing of patients or their representatives and filing claims with issuers;

2. modify their billing practices to encompass the coding charges for all billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes, and procedures required under this regulation.

E. Submitted billing and claim filing forms not complying with the minimum requirements of this regulation shall be considered to be in noncompliance with the regulation and issuers shall have the right to deny reimbursement until such time as the forms are in compliance with this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

Chapter 25. Regulation 49—Billing Audit Guidelines

§2501. Purpose

A. The purpose of this regulation is to provide for the reasonable standardization of statewide billing audit guidelines for health care providers and payers; and to provide for related matters. These rules are based, at least in part, on the National Health Care Billing Audit Guidelines and variances in order to comply with R.S. 22:12.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2503. Applicability and Scope

A. This regulation shall apply to health care providers and payers. The provider and/or payer involved in the billing audit shall be responsible for the conduct and results of the billing audit, whether conducted by an employee or by contract with another firm. This means that the provider and payer shall:

1. exercise proper supervision of the process to ensure that the audit is conducted according to the spirit of the regulations set forth here;

2. be aware of the actions being undertaken by the auditor in connection with the billing audit and its related activities; and

3. take prompt remedial action if inappropriate behavior by the auditor is discovered.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2505. Definitions

A. For purposes of this regulation:

Ambulatory Surgical Center—ambulatory surgical center as defined in R.S. 40:2133(A).

Billing Audit—a process to determine whether data in a provider's medical record documents or supports services listed on a provider's bill. Billing audit does not mean a review of medical necessity of services provided, cost or pricing policy of a facility, and adjustments for "usual and customary".

Health Record which Shall Mean Medical Record—any compilation of charts, records, reports, documents, and other memoranda prepared by a health care provider, wherever located, to record or indicate the past or present condition, sickness, or disease, and treatment rendered, physical or mental, of a patient.

Historic Error Rate—the average error found during all audits conducted by external qualified billing auditors during the preceding calendar year. It shall be calculated by totaling the net adjustments made to all accounts audited by external qualified billing auditors during that year and dividing that total by the total amount claimed by the audited party to be due on those accounts immediately preceding the audit. This calculation results is an average error rate for all externally audited cases expressed as a percentage.

Hospital—hospital as defined in R.S. 40:2102(A).

Patient—a natural person who receives or should have received health care from a health care provider, under a contract, expressed or implied.

Qualified Billing Auditor—a person employed by a corporation or firm that is recognized as competent to perform or coordinate billing audits and that has explicit policies and procedures protecting the confidentiality of all the patient information in their possession and disposal of this information.

Unbilled Charges—the volume of services indicated on a bill is less than the volume identified in a provider's health record documentation; also known as undercharges.

Unsupported or Undocumented Charges—the volume of services indicated on a bill exceeds the total volume identified in a provider's health record documentation; also known as overcharges.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2507. Qualifications of Auditors and Audit Coordinators

A. All persons performing billing audits, as well as persons functioning as provider audit coordinators, shall have appropriate knowledge, experience, and/or expertise in a number of areas of health care including, but not limited to, the following areas:

1. format and content of the health record as well as other forms of medical/clinical documentation;

2. generally accepted auditing principles and practices as they may apply to billing audits;

3. billing claims forms, including the UB-82 and UB 92, the HCFA 1500, and charging and billing procedures;

4. all state and federal regulations concerning the use, disclosure, and confidentiality of all patient records; and

5. specific critical care units, specialty areas, and/or ancillary units involved in a particular audit.

B. Providers or payers who encounter audit personnel who do not meet these qualifications shall immediately contact the auditor's firm or sponsoring party, but may not request information unrelated to the areas listed in §2507.A.

C. Audit personnel shall be able to work with a variety of health care personnel and patients. They shall always conduct themselves in an acceptable, professional manner and adhere to ethical standards, confidentiality requirements, and objectivity. They shall completely document their findings and problems.

D. All unsupported or unbilled charges identified in the course of an audit must be documented in the audit report by the auditor. Individual audit personnel shall not be placed in a situation through their remuneration, benefits, contingency fees, or other instructions that would call their findings into question. In other words, compensation of audit personnel shall be structured so that it does not create any incentives to produce questionable audit findings. Providers or payers who encounter an individual who appears to be involved in a conflict of interest shall contact the appropriate management of the sponsoring organization.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2509. Notification of Audit

A. Payers and providers shall make every effort to resolve billing inquiries directly. To support this process, the name and contact telephone number (and/or facsimile number) of each payer or provider representative shall be exchanged no later than the time of billing for a provider and the point of first inquiry by a payer.

B. If a satisfactory resolution of the questions surrounding the bill is not achieved by payer and provider representatives, then a full audit process may be initiated by the payer.

C. Generally, billing audits require documentation from or review of a patient's health record and other similar medical/clinical documentation. Health records exist primarily to ensure continuity of care for a patient; therefore, the use of a patient's record for an audit must be secondary to its use in patient care.

D. To alleviate the potential conflict with clinical uses of the health record and to reduce the cost of conducting a necessary audit, all payer billing audits shall begin with a notification to the provider of an intent to audit. Notification

of the provider by the qualified billing auditor shall occur no later than four months following receipt of the final bill by the payer. Once notified, the provider shall respond to the qualified billing auditor within one month with a schedule for the conduct of the audit. The qualified billing auditor shall complete the audit within six months of receipt of the final bill by the payer. When there is a substantial and continuing relationship between a payer and a provider, this relationship may warrant a notification, response, and audit schedule other than that outlined herein. Also, each party shall make reasonable provisions to accommodate circumstances in which the schedule specified herein cannot be met by the other party.

E. All billing audits shall be conducted "on site."

F. All requests, whether telephonically or written, for billing audits shall include the following information:

1. the basis of the payer's intent to conduct an audit on a particular bill or group of bills (when the intent is to audit only specific charges or portions of the bill(s), this information should be included in the notification request);

2. name of the patient;

3. admit and discharge dates;

4. name of the auditor and the name of the audit firm;

5. medical record number and provider's patient account number; and

6. whom to contact at the payer institution and, if applicable, at the agent institution to discuss this request and schedule the audit.

G. Providers who cannot accommodate an audit request that conforms with these guidelines shall explain why the request cannot be met by the provider in a reasonable period of time. Auditors shall group audits to increase efficiency whenever possible.

1. If a provider believes an auditor will have problems accessing records, the provider shall notify the auditor prior to the scheduled date of audit. Providers shall supply the auditor/payer with any information that could affect the efficiency of the audit once the auditor is on site.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2511. Provider Audit Coordinators

A. Providers shall designate an individual to coordinate all billing audit activities. An audit coordinator shall have the same qualifications as an auditor (see §2507, Qualifications of Auditors and Audit Coordinators). Duties of an audit coordinator include, but are not limited to, the coordination of the following areas:

1. scheduling an audit;

2. advising other provider personnel/departments of a pending audit;

3. ensure that the condition of admission is part of the medical record;

4. verifying that the auditor is an authorized representative of the payer;

5. gathering the necessary documents for the audit;

6. coordinating auditor requests for information, space in which to conduct an audit, and access to records and provider personnel;

7. orienting auditors to hospital audit procedures, record documentation conventions, and billing practices;

8. acting as a liaison between the auditor and other hospital personnel;

9. conducting an exit interview with the auditor to answer questions and review audit findings;

10. reviewing the auditor's final written report and following up on any charges still in dispute;

11. arranging for payment as applicable; and

12. arranging for any required adjustment to bills or refunds.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2513. Conditions and Scheduling of Audits

A. In order to have a fair, efficient, and effective audit process, providers and payer auditors shall adhere to the following requirements:

1. whatever the original intended purpose of the billing audit, all parties shall agree to recognize, record, or present any identified unsupported or unbilled charges discovered by the audit parties;

2. late billing shall not be precluded by the scheduling of an audit;

3. the parties involved in the audit shall mutually agree to set and adhere to a predetermined time frame for the resolution of any discrepancies, questions, or errors that surface in the audit;

4. an exit conference and a written report shall be part of each audit. If the provider waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit;

5. if the provider decides to contest the findings, the auditor shall be informed immediately;

6. once both parties agree to the audit findings, audit results are final;

7. all personnel involved shall maintain a professional courteous manner and resolve all misunderstandings amicably; and

8. at times, the audit will note ongoing problems either with the billing or documentation process. When this situation occurs, and it cannot be corrected as part of the exit process, the management of the provider or payer organization shall be contacted to identify the situation and take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate ongoing problems or questions whenever possible as part of the audit process.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2515. Confidentiality and Authorizations

A. All parties to a billing audit shall comply with all federal and state laws and any contractual agreements regarding the confidentiality of patient information.

B. The release of medical records requires authorization from the patient. Such authorization shall be provided for in the condition of admission, or equivalent statement, procured by the hospital or ambulatory surgical center upon admission of the patient. If no such statement is obtained, an authorization for a billing audit shall be required. Authorization need not be specific to the insurer or auditor conducting the audit.

C. Such authorization shall be obtained by the billing audit firm or payer and shall include:

1. the name of the payer, and if applicable, the name of the audit firm that is to receive the information;

2. the name of the institution that is to release the information;

3. the full name, birth date, and address of the patient whose records are to be released;

4. the extent or nature of the information to be released, with inclusive dates of treatment; and

5. the provider's patient account number; and

6. the signature of the patient or his legal representative and the date the consent is signed.

D. A patient's assignment of benefits shall include a presumption of authorization to review records.

E. The audit coordinator or medical records representative shall confirm for the audit representative that a condition of admission statement is available for the particular audit that needs scheduling.

F. The provider will inform the requestor, on a timely basis, if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedure affecting the review. These institutional confidentiality policies shall not be specifically oriented in order to delay an external audit.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2517. Documentation

A. Verification of charges will include the investigation of whether or not:

1. charges are reported on the bill accurately;

2. services are documented in health or other appropriate records as having been rendered to the patient; and

3. services were delivered by the institution in compliance with the physician's plan of treatment. (In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established institutional policies, procedures, or professional licensure standards. Many procedures include items that are not specifically documented in a record but are referenced in medical or clinical policies. All such policies should be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Health Care Organizations or other accreditation of health care organizations or other accreditation agencies. Policies should be available for review by the auditor.)

B. The health record documents clinical data on diagnoses, treatments, and outcomes. It was not designed to be a billing document. A patient health record generally documents pertinent information related to care. The health record may not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the provider's ancillary departments in the form of department treatment logs, daily records, individual service/order tickets, and other documents.

C. Auditors may have to review a number of other documents to determine valid charges. Auditors must recognize that these sources of information are accepted as reasonable evidence that the services ordered by the physician were actually provided to the patient. Providers must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the health record and in the ancillary records and/or logs. These procedures document that services have been properly ordered for and delivered to patients. When sources other than the health record are providing such documentation, the provider shall notify the auditor and make those sources available to the auditor.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2519. Fees and Payments

A. Payment of a bill shall be made promptly and shall not be delayed by an audit process. Payment on a submitted bill from a third party payer shall be based on amounts billed and covered by the patient's benefit plan.

B. Billing audits shall be made in accordance with one of the following three audit fee and payment schedules:

1. a $100 audit fee shall be paid by the auditor to the audited party. Such audited party shall not require payment greater than 100 percent of the audited party's submitted bill minus such party's historic error rate;

2. in those instances where the audited party has had less than 12 audits in a calendar year, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be 7 percent; and

3. the $100 fee shall be waived in the following scenarios:

a. payment of 100 percent of the covered benefit plan has been made; or

b. the on site audit commencement date exceeds 60 days from the date of the request for audit; or

c. audit fees are not required or are otherwise being waived.

C. Each provider's billing audit coordinator shall maintain a log containing the results of all audits performed by external qualified billing auditors in the preceding 24 months. In cases where the log is not complete for the past 24 months, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be seven percent.

D. The audit log shall contain the amount billed immediately preceding the audit, and net adjustment resulting from the audit, the name, address, and phone number of the audit firm conducting the audit, and the name of the qualified billing auditor who performed the audit. Audits whose results are in dispute and audits ordered by the provider and conducted by its own or contracted audit organization shall not be included in the audit log. The audit log shall be available at all times during regular business hours for inspection by any qualified billing auditor.

E. Audit fees, if needed, are to be paid upon commencement of the on site billing audit. Any payment identified in the audit results that is owed to either party by the other shall be settled by the audit parties within a reasonable period of time-not to exceed 30 days after completion of the audit unless the two parties agree otherwise.

F. Neither the provider nor the qualified billing auditor shall require a billing, or re-billing, or refund request following final audit determination, but all findings shall be netted, and the final result will be due by the relevant party without additional billing.

G. Photocopying and duplication charges shall be paid in accordance with R.S. 40:1299.96.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

Chapter 27. Regulation 51—Individual Health Insurance Rating Requirements

§2701. Purpose

A. The purpose of this rule is to facilitate the implementation of R.S. 22:228.6. The intent of R.S. 22:228.6 is to establish a modified community rating system for health care premiums in the state. Adherence to this rule by individual health and accident insurance carriers will bring carriers into compliance with R.S. 22:228.6. The provisions of R.S. 22:228.6 not specifically addressed in this rule are in full force and effect as if they were addressed herein.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

§2703. Applicability and Scope

A. R.S. 22:228.6 applies to the rating of small group and individual health benefit plans. This particular regulation applies to the compliance of individual health benefit plans only.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

§2705. Definitions

Individual Policy—any hospital, health or medical expense insurance policy, hospital or medical services contract, health and accident insurance policy, or any other insurance contract of this type covering any one person with or without eligible family members. Not included under this definition are continuation or conversion policies, or insurance policies written to cover specified disease, hospital indemnity, accident only, credit, dental, or disability income, Medicare supplementary or long-term care, or other limited supplemental benefit insurance policies. *Individual policy* also means a policy issued to an individual or individual member of an association where the individual pays for the entire premium.

Manual Rate—the lowest premium rate charged or which could have been charged under a rating system by the carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage. Coverage and case characteristic variations in the manual must bear a reasonable relationship to normal expectations based on experience of standard risks. The use of experience alone is not sufficient justification for variations beyond such expectations.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

§2707. Restrictions on Premium Rates

A. Each individual health and accident insurance carrier shall define a rate manual for its individual business. The manual will be used to determine compliance with the intent of the law for the relationship of one individual to the others within a carrier's block of individual business. For the purpose of this rule, all individual businesses shall be considered one class, and that class shall not be subject to R.S. 22:228.2.A.(1).

B. R.S. 22:228.6.b(2)(e), requires, in substance, that the premium rates charges during a rating period to individuals may not vary from the index rate by more than 20 percent following January 1, 1994. This requirement shall be met for each individual if the ratio of the premium charged the individual to that calculated from the rate manual is between 1 and 1.5 for rating periods following January 1, 1994.

C. For individual health insurance, the acceptability of a proposed rate increase for an individual contract or certificate shall be determined by comparing the desired renewal premium to a maximum renewal premium calculated as follows.

1. Calculate a premium using manual rates for the individual from the rate manual in effect at the renewal date, based on the case characteristics of the individual and the current benefit plan.

2. For rating periods following January 1, 1994, the maximum renewal premium is 1.5 times the manual rate in §2707.C.1.

3. In cases where the individual policy or contract does not have a specified renewal date, the anniversary of the date of issue shall be used as a proxy for the renewal date.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

§2709. General Provisions

A. Other methods may be used if it is demonstrated to the satisfaction of the department that such methods are designed to attain and/or enhance the purposes of R.S. 22:228.6. Such a demonstration shall at least consist of an actuarial certification and the methodology for testing compliance with R.S. 22:228.6.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

Chapter 29. Regulation 52—Small Group Health Insurance Rating Requirements

§2901. Purpose

A. The purpose of this rule is to facilitate the implementation of R.S. 22:228.2 and 22:228.6. The intent of R.S. 22:228.2 is to restrict premium rate increases and the intent of R.S. 22:228.6 is to establish a modified community rating system for health care premiums in the state. Adherence to this rule by small employer health and accident insurance carriers will bring them into compliance with R.S. 22:228.2 and 22:228.6. The provisions of R.S. 22:228.2 and R.S. 22:228.6 not specifically addressed in this rule are in full force and effect as if they were addressed herein.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10, 22:228.2, and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:315 (March 1994), amended LR 21:1338 (December 1995).

§2903. Applicability and Scope

A. R.S. 22:228.2 applies to the rating of small group health benefit plans only. R.S. 22:228.6 applies to the rating of small group and individual health benefit plans. This particular regulation applies to the compliance of small group health benefit plans and association sponsored plans where group and individual member plans are combined.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10, 22:228.2, and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:315 (March 1994), amended LR 21:1338 (December 1995).

§2905. Definitions

Manual Rate—for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage. Coverage and case characteristic variations in the manual must bear a reasonable relationship to normal expectations based on experience of standard risks. The use of experience alone is not sufficient justification for variations beyond such expectations.

Representative Census—the average characteristics of all groups in a class of business insured by an insurance carrier.

Small Group and Small Employer—any person, firm, corporation, partnership or association actively engaged in business which, on at least 50 percent of its working days during the preceding year, employed no less than three nor more than 35 eligible employees or association members and

does not include policies whose premiums are paid for by the individual employee alone. However, any association sponsored plan, which includes a combination of small groups and individuals, shall be considered as a small group and governed under §§22:228.2 and 22:228.6.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10, 22:228.2, and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:315 (March 1994), amended LR 21:1338 (December 1995).

§2907. Restrictions on Premium Rates

A. Each class of business shall have its own rate manual. The manual will be used to determine compliance with the intent of the law for the relationship of one employer group to the others within a class. The rate manual will also be used to determine compliance with the required relationship of one class to the other classes.

B. R.S. 22:228.2.A(2) and R.S. 22:228.6.B(2)(e), Louisiana Statutes, require, in substance, that within a class the premium rates charged to small employers during a rating period may not vary from the index rate by more than 20 percent following January 1, 1994. This requirement shall be met for each small employer if the ratio of the premium charged the employer to that calculated from the rate manual is between 1 and 1.67 for rating periods from September 30, 1992 through December 31, 1993 and between 1 and 1.50 for rating periods following January 1, 1994.

C. R.S. 22:228.2.A.(I) requires, that "the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent." This requirement shall be met as follows.

1. The company shall define a representative census of its business.

2. On December 31 of each calendar year, the company shall calculate a dollar rate according to the manual rate in effect for the rating period beginning December 31 for each class, using an actuarially equivalent plan of benefits for the representative census.

3. A conversion to an index dollar rate shall be made from the manual dollar rate for each class calculated in §2907.C.2. This conversion shall be made by multiplying the manual dollar rate for each class in §2907.C.2 by the appropriate factor for each class calculated as follows:

a. calculate the ratio of the highest premium charged or which could have been charged as of the last renewal or issue date, according to the description of the rating practices for that class as required by R.S. 22:228.5, to the manual rate in affect at the last renewal or issue date for each group still in force as of December 31;

b. the sum of 1.00 plus the highest ratio calculated from §2907.C.3.a divided by two shall be used as the conversion factor in §2907.C.3 above. For the calendar year 1993, if the highest ratio calculated in §2907.C.3.a is greater than 1.67, then 1.67 shall be used as the highest ratio. This conversion factor should be calculated for each class of business. For calendar year 1994 and thereafter, 1.5 shall be used above.

4. The ratio of the highest index dollar rate for any class cannot exceed the lowest index dollar rate for any other class calculated in §2907.C.3 by more than 20 percent.

5. This test shall be performed on December 31 every year. Other methods may be used if it is demonstrated to the satisfaction of the department that the result will be the same.

D. R.S. 22:228.2.A.(3)(a)-(c) limits the percentage increase in the premium rate charge to small employers for a new rating period. In capsule form, the increase may not exceed the sum of the following:

1. the percentage change in the new business premium rate;

2. an adjustment, not to exceed 15 percent annually and prorated for rating periods of less than one year due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer; and

3. any adjustments due to change in coverage or case characteristics of the small employer.

E. The limit of a proposed rate increase for a small employer shall be determined by comparing the desired renewal premium to a maximum renewal premium calculated as follows.

1. Calculate a premium using manual rates for the small employer from the rate manual in effect at the renewal date, based on the current census of the small employer and the current benefit plan.

2. Calculate a premium using manual rates for the small employer from the rate manual in effect at the beginning of the rating period, based on the census and the benefit plan then in effect or based on the current plan with an actuarially equivalent adjustment for the difference in benefits between plans.

3. Section 2907.E.1 divided by §2907.E.2 multiplied by the gross premium in effect at the beginning of the rating period gives the maximum renewal premium for the next rating period for the allowance of §2907.D.1 and §2907.D.3.

4. A percentage of the gross premium in force prior to renewal may be added to §2907.E.3. The percentage is 15 percent per year prorated for the months elapsed between the last and current rating dates.

5. Section 2907.E.3 plus §2907.E.4 is the maximum renewal premium subject to the following:

a. calculate the ratio of the maximum renewal premium in §2907.E.5 to the manual rate in §2907.E.1;

b. for rating periods through December 31, 1993, if §2907.E.5.a exceeds 1.67, then 1.67 multiplied by the manual rate in §2907.E.1 is the maximum renewal premium, not the renewal premium in §2907.E. For rating periods after December 31, 1993, 1.50 should be substituted for 1.67.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10, 22:228.2, and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:315 (March 1994), amended LR 21:1338 (December 1995).

§2909. General Provisions

A. Other methods may be used to comply with R.S.22:228.2 and R.S. 22:228.6 if it is demonstrated to the satisfaction of the department that such methods are designed to attain and/or enhance the purposes of R.S. 22:228.2 and R.S. 22:228.6. Such demonstration shall at least consist of an actuarial certification and the methodology for testing compliance with R.S. 22:228.2 and R.S. 22:228.6.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10, 22:228.2, and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:315 (March 1994), amended LR 21:1338 (December 1995).

Chapter 31. Regulation 53—Basic Health Insurance Plan Pilot Program

§3101. Purposes

A. The purpose of this regulation is to provide for the implementation of the Louisiana Basic Health Insurance Plan Pilot Program (LA Health); and to provide for related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3103. Applicability and Scope

A. These regulations shall apply to all insurance carriers, health maintenance organizations, employers, health care providers and individuals that apply to cover or to be covered by the Louisiana Basic Health Insurance Pilot Program (LA Health).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3105. Definitions

A. For purposes of this regulation:

Accidental Injury—bodily injury sustained as the result of an unforeseen event and which is the direct reason for receiving care and treatment (independent of disease, bodily infirmity or any other cause). Such care shall occur while coverage under the pilot is in force. It does not include injuries for which benefits are provided under any workers' compensation, employers' liability, or for which another party is liable under automobile, property and casualty, and other coverage.

Admission—begins the first day an insured becomes a registered hospital inpatient and continues until insured is discharged from the facility.

Adult—an individual who is greater than 24 but less than 65 years of age.

Agent—an individual appointed, in writing, by an insurer to solicit applications for a policy of insurance or to negotiate a policy of insurance on its behalf licensed in accordance with R.S. 22:1112.

Applicant—an individual who applies for coverage under the LA Health Plan.

Authorized Carrier—the health insurance carrier or health maintenance organization licensed and in compliance with the Insurance Code certified by the department to offer the LA Health Plan.

Benefit Payment—the amount the authorized carrier will pay for covered services. See §§3127-3133 of this regulation.

Benefit Period—one year, also referred to as *year* or *calendar year*. The benefit period does not begin before the insured's effective date. The benefit period does not continue after the insured's coverage ends.

Clinic—a facility for the diagnosis, care and treatment of outpatients.

Commissioner—the Commissioner of Insurance.

Co-Payment—the cost-sharing fee charged to an insured under LA Health as specified in the contract between the authorized carrier for LA Health and the insured.

Department—the Department of Insurance.

Dependent—

a. the spouse and all unmarried children under the age of 24;

b. children include natural children, legally adopted children and step-children. Also included are children (or children of a spouse) for whom an insured has legal responsibility resulting from a valid court decree. Foster children that an insured expects to raise to adulthood and that live with an insured in a regular parent-child relationship are considered children;

c. students who are unmarried children who have not yet attained the age of 24 and who are enrolled as full-time students and who are dependent upon the primary insured;

d. mentally retarded or physically handicapped children remain covered to age 21 at which time they are eligible for their own individual coverage;

e. a child's coverage ends when any of the following occurs:

i. marriage or attaining age 21 (whichever comes first);

ii. termination of an insured's coverage under the LA Health Plan; or

iii. if a child over age 21 no longer qualifies as a full-time student.

Effective Date—the date an applicant becomes eligible for coverage under an authorized carrier for the LA Health Plan.

Hospital—an institution, licensed by the state, which:

a. provides inpatient services and is compensated by or on behalf of its patients;

b. primarily provides medical and surgical facilities to diagnose, treat and care for the injured or sick;

c. has a staff of physicians licensed to practice medicine by the Louisiana State Board of Medical Examiners;

d. provides nursing care by registered nurses or:

NOTE: The term *hospital* does not mean:

1. an extended care facility, nursing home, community based care, or group home;

2. a place of rest;

3. a facility for the aged;

4. a custodial institution whose primary purpose is to furnish food, shelter, training, or unskilled or nonmedical services; or

5. an institution for exceptional or handicapped children. licensed practical nurses on duty 24-hours-a-day.

Insured—an individual domiciled in this state who is eligible to receive benefits from an authorized carrier under the LA Health Plan.

LA Health—the Louisiana Basic Health Insurance Plan Pilot Program.

Mental and Nervous Disorders—includes (whether organic or nonorganic, whether of biological, nonbiological, genetic, chemical, or nonchemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in Diagnostic and Statistical Manual of Mental Disorders (DSM-IIIR).

Minor Dependent—a dependent under the age of 24.

Non-Smoker—an individual who has not smoked cigarettes, cigars, pipes or other substances within the past year.

Participating Hospital—a hospital located in Louisiana which has concluded a written agreement with, and in form approved by, an authorized carrier under the LA Health Plan.

Participating Provider—a licensed health care provider who has concluded an agreement with, and in form approved by, an authorized carrier under the LA Health Plan to serve those insured by LA Health.

Pilot Plan—a plan that provides an insured with health insurance under the LA Health program and is governed by R.S. 22:244-247 and authorized by the commissioner.

Pilot Program—the program of health insurance which is authorized by R.S. 22:244-247.

Provider—includes any discipline licensed by the state of Louisiana to provide and be directly reimbursed for services covered by the LA Health Plan including, but not limited to, the following:

a. doctor of medicine (M.D.) legally entitled to practice medicine and perform surgery by the Louisiana State Board of Medical Examiners;

b. doctor of chiropractic (D.C.) legally entitled to practice chiropractic services;

c. doctor of podiatric medicine (D.P.M.) legally entitled to practice podiatry;

d. all providers shall be licensed by the state of Louisiana.

Semiprivate Room—a hospital room which has 2, 3, or 4 beds.

Service Area—that part of the state of Louisiana in which the authorized carrier is applying to offer or is offering the pilot plan.

Skilled Nursing Care—care required, while recovering from an illness or injury, which is received in a skilled nursing facility. This care requires a level of care or services less than that in a hospital, but more than could be given in the patient's home or in a nursing home not certified as a skilled nursing facility.

Smoker—an individual who has smoked cigarettes, cigars, pipes or other substances within the past year or who is currently smoking cigarettes, cigars, pipes or other substances.

Utilization Review—a function performed by an authorized carrier under the LA Health Plan or an entity selected by the carrier to review and approve whether the services provided, or to be provided, are medically necessary including, but not limited to, whether acute hospitalization, length of stay, outpatient care, or diagnostic services are appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3107. Pilot Plan in General

A. An authorized carrier under the LA Health Plan shall deliver coverage for the plan through a fully insured individual health insurance policy or health maintenance organization membership plan. Each authorized carrier shall design the plan to minimize the cost of delivery and administration of the plan and medical services for covered benefits.

B. An authorized carrier may provide coverage to individuals or their dependents or both. However, an authorized carrier may offer coverage for all adults or all children, or the individual's entire family.

C. An authorized carrier may accept partial payment for individuals enrolled under the LA Health Plan from such individual's employers; however, such payment shall not be considered to be part of that employer's group health insurance if the employer offers other health insurance. Furthermore, such payment by an employer shall not change the status of the coverage. It remains an individual policy.

D. Employers who agree to make partial payment for individuals enrolled under the LA Health Plan may be authorized by the enrolled employee to deduct insurance premiums for the plan. Such a payroll deduction shall not be construed to alter the plan's status as an individual insurance policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3109. Pilot Plan Authorized Carrier

A. An authorized carrier shall be responsible for the operation of the LA Health Plan for which it has been certified to operate.

B. An authorized carrier shall be authorized to participate in the LA Health Plan by entering into a pilot plan agreement with the commissioner. The agreement shall incorporate the application procedure for health and accident insurance policy forms and shall not be authorized until such policy forms have been approved. Such approval shall include any revisions to the application which are agreed upon by the commissioner and the authorized carrier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3111. Application Process

A. An applicant to become an authorized carrier shall apply for authorization to operate a LA Health Plan by submitting an application to the commissioner. The applicant shall provide at least the following information:

1. the name of the carrier and a description of its role in funding, insuring, and operating the pilot plan;

2. a full description of how the pilot plan will operate, including plan benefits, coverage limitations, premiums, provider networks, managed care provisions, and administrative procedures of the plan;

3. a listing of participating providers by service category and geographic service area;

4. a draft of all materials describing the LA Health Plan that are intended for distribution to insured members;

5. a description of the financial and organizational resources supporting the pilot plan.

B. Applications submitted to the commissioner's office will, furthermore, be judged on their ability to attain the intent of the LA Health Plan according to the following criteria:

1. their ability to guarantee issue of the LA Health Plan to the eligible population;

2. their ability to provide the LA Health Plan as a community rated product;

3. their ability to provide the LA Health Plan at premium amounts which are significantly lower than premium amounts for standard market policies of health and accident insurance;

4. their ability to implement cost containment features;

5. the degree to which their plan of benefits under the LA Health Plan emphasizes primary health care services designed to prevent the need for more expensive health care services; and

6. variance beneficial to the eligible LA Health population from the minimum standards established for the LA Health Plan's benefits outlined in §§3127-3133 of this regulation.

C. Applications may be submitted to the commissioner's office on or after the effective date of this regulation. Applications received before the effective date shall be subject to any revisions required by changes in this regulation. Applications received in the commissioner's office after 90 days of the effective date of this regulation will not be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3113. Authorization of Pilot Plan

A. The commissioner shall have sole discretion regarding the authorization of carriers under the LA Health Plan. Applications will be evaluated by the commissioner in order of their receipt. The commissioner shall have sole discretion in determining if an application is complete. Within 30 days of receiving a complete application, but in no event prior to the effective date of this regulation, the commissioner shall provide a written notice of findings to the applying carrier. That notice shall:

1. specify approval or rejection of the application and the grounds for that decision; or

2. specify additional information which is needed to clarify the application and a deadline for submitting that information. Within 30 days of receiving timely additional information, the commissioner shall provide a written notice of findings as described in §3113.A.1. If the additional information is not provided by the deadline, the application shall be rejected.

B. In evaluating and authorizing carriers under the LA Health Plan, the commissioner may consider, but not be limited to, the following criteria:

1. the extent to which the plan helps the pilot program achieve a diversity of participants and plan designs;

2. the potential of the plan to fulfill the objectives of the pilot;

3. the financial and organizational resources of the carrier;

4. the ability of the plan to meet the evaluation criteria described in §3117 of this regulation;

5. the resources available within the department to regulate the pilot program.

C. The LA Health Plan shall not be issued or delivered to an applicant for the plan until a copy of the form is filed and approved by the commissioner. The commissioner shall review these forms in accordance with the *Insurance Code*.

D. Each authorized carrier in the pilot plan shall file with the commissioner the rates, rating plans, and rating systems that will be applicable to the LA Health Plan.

E. The commissioner, in accordance with the *Insurance Code*, may make, or cause to be made, an examination of the books and records of the authorized carrier of the LA Health Plan as the commissioner deems necessary to ensure compliance with these regulations and the pilot plan agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3115. Revocation of an Authorized Carrier's Authority

A. The commissioner may revoke the authority of an authorized carrier at any time if, in the judgement of the commissioner, one or more of the following, or similar, conditions exist:

1. the authorized carrier's plan does not comply with R.S. 22:244-246 or the *Insurance Code*;

2. an authorized carrier becomes subject to suspension or revocation of its certificate or authority under the *Insurance Code*;

3. the authorized carrier's plan is deficient regarding timeliness, accuracy, customer service, or other administrative practices;

4. the authorized carrier's plan does not meet the evaluation requirements or reporting requirements described in §3117 of this regulation;

5. a breach of the plan of the authorized carrier agreement occurs;

6. the successful operation of the plan of the authorized carrier is jeopardized by a weakness in the financial or operational status of the authorized carrier.

B. The commissioner shall provide written notice to the authorized carrier in advance of any revocation.

C. In providing notice, the commissioner shall specify the concerns at issue and shall request a written statement for the authorized carrier, to be provided within 15 days of the date of notice, describing how they propose to remedy the concerns.

D. Upon completion of review of the proposed remedy, the commissioner shall provide a written response which:

1. approves the remedy; or

2. requests additional information; or

3. provides notice of the proposed revocation of the carrier's authority to participate in the pilot plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3117. Evaluation and Reporting Requirements

A. Each plan shall be evaluated by the commissioner on its ability to enhance the delivery and improve the cost effectiveness of medical services for the insured. This evaluation shall compare the results of the plan's coverage. The criteria and methodology for this evaluation shall be determined by the commissioner, with prior advice of the authorized carrier. An authorized carrier shall agree to participate in the evaluation process as a condition of operating under the LA Health Plan.

B. An authorized carrier shall provide the following reports to the commissioner:

1. a written overview of plan results for each six months of plan operations. The report shall outline the operating results of the plan, including significant issues which arose and the responding actions taken by the plan and shall specify the number of insured and a demographic breakdown of those enrolled, the premiums collected, and utilization reports. The report shall be compiled after each six-month period of plan operation and shall be mailed to the commissioner by the twentieth day of the subsequent month;

2. all reports required in accordance with §3117.A.

C. Nothing in this rule shall be construed to limit the commissioner's authority to require information from an authorized carrier as necessary to monitor the carrier's compliance with the requirements of the LA Health Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3119. Premium Taxes

A. Premium taxes required under R.S. 22:1062 shall be imposed on an authorized carrier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3121. Guaranty Association

A. All applicable assessments for the Louisiana Life and Health Insurance Guaranty Association shall be imposed on an authorized carrier in accordance with R.S. 22:1395.1-1395.19.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3123. Health Insurance Agents

A. For purposes of serving a LA Health Plan policy or soliciting prospective insureds for such a policy, agents possessing a health insurance license shall be deemed to be servicing and soliciting within the scope of their license, pursuant to R.S. 22:1111-1119 and 22:2011 of the *Louisiana Insurance Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3125. Eligibility

A. Eligibility for coverage and the effective date for an insured shall be determined by the authorized carrier after an applicant has returned the application for coverage to the authorized carrier and has been approved by said carrier. Eligibility for the LA Health Plan is limited to Louisiana residents with income levels below 250 percent of the federal poverty level. Individuals with major medical accident and health insurance coverage, individuals who are eligible for coverage under the Medicaid or Medicare programs, and those who have voluntarily canceled their accident and health insurance coverage during the last six months are not eligible under the LA Health Plan. The only exception to this requirement is for those individual eligibles who are without coverage because their coverage furnished in accordance with R.S. 22:215.13, group health continuation coverage, has expired; or for those individual eligibles with significantly reduced coverage through benefit riders or limitations.

B. Eligible adults may choose to purchase coverage only for themselves or all their children, or the entire family.

C. Unmarried eligible dependent children are eligible for coverage to age 21. Those children who are full-time students (after high school) in an institution of higher learning may remain covered to age 24. Such children shall be dependents under federal income tax laws.

D. A newborn child or an adopted child is covered, subject to §3125.E, from the moment of birth or date of assumption of legal responsibility to age 21, unless married before age 21, in the case of a family enrolled. The child's coverage is no different than that of the primary insured adult. An additional premium payment is required.

E. A newborn child or an adopted child of an enrolled individual is automatically covered for 31 days only in the case of an individual enrolled. In order for a newborn child or an adopted child to receive coverage past the thirty-first day, the enrolled individual shall complete an application form and pay the necessary premium for plan coverage.

F. If an eligible individual does not apply for coverage under the plan for himself or any eligible dependent, then application may be made later. If such individual is approved for coverage, the effective date of coverage will be the next month following approval of the application and payment of the necessary coverage.

G. Insureds may reduce the number of individuals covered at any time by submitting a change of coverage form. Such changes become effective on the due date of the LA Health Plan contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3127. Benefits

A. The LA Health Plan is a basic health insurance plan providing primary and preventive health care services. Health care services are to be furnished by participating hospitals, clinics, and health care providers who have agreed to provide services under the LA Health Plan. An authorized carrier shall supply insured individuals under the LA Health Plan with a list of participating providers.

B. No requirement of the *Louisiana Insurance Code* relating to minimum required policy benefits, other than the minimum standards contained in this regulation or in R.S. 22:244-247, shall apply to the LA Health Plan, its insureds, or the authorized carrier.

C. The benefits provided by the LA Health Plan are payable for services provided by a participating provider only. LA Health Plan insureds shall receive care from a participating provider. No coverage is provided with any other providers. Insureds shall pay in full for care they receive if the provider they utilize is not a participating provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3129. Hospital Services

A. The LA Health Plan provides for the following minimum or their actuarial equivalent inpatient hospital services:

1. 15 days of hospital inpatient care (hospital/medical) per calendar year. A $50 per day co-payment is required;

2. surgical procedures and related expenses are covered up to a maximum of $5,000 per insured per calendar year. A $50 per surgical procedure co-payment is required;

3. the LA Health Plan will pay for covered expenses incurred for services in a participating hospital for the following services based on the limitations above;

a. daily room, board, and general nursing care at the semiprivate rate charged by the participating hospital;

b. confinement in an intensive care or coronary care unit with such payment being in lieu of expenses covered under §3129.A.3.a;

c. services and supplies furnished by the participating hospital which are necessary for inpatient medical care and treatment, including diagnostic x-ray and lab services;

4. maternity care;

5. newborn nursery care from the moment of birth;

6. medical care and treatment by a participating provider while confined as an inpatient in a hospital;

7. radiological services by a licensed radiologist while confined as an inpatient in a hospital;

8. radiation therapy.

B. The LA Health Plan provides for the following minimum or their actuarial equivalent outpatient hospital services:

1. the LA Health Plan shall pay covered expenses incurred for outpatient diagnostic services for pre-admission tests, diagnostic X-ray and laboratory services at a participating facility. The outpatient benefit is limited to $1,000 per insured per calendar year;

2. payment of outpatient hospital services is prohibited on the date of admission or during an admitted stay in a hospital as an inpatient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3131. Emergency Room Benefits

A. The LA Health Plan provides for the following emergency room benefits:

1. outpatient health care received in the emergency room of a participating hospital is covered, limited to a maximum of $1,500 per insured per calendar year. This benefit is subject to an $85 co-payment per visit;

2. the co-payment of $85 per visit shall be waived if such a visit is followed by an admission to the participating hospital for the care of the illness or injury for which the person was treated in the emergency room.

B. An insured receiving emergency room care resulting from an illness or injury outside the service area of the authorized carrier shall have benefits of 50 percent of those for services received at a participating hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3133. Provider Services

A. The LA Health Plan provides for the following minimum, or their actuarial equivalent, primary health care provider services.

1. The LA Health Plan will provide for health care provider services, with such care including the general treatment of illness and diagnostic studies used to diagnose the cause of an illness.

2. All care received by a LA Health insured shall be related to the cause or symptom of the insured's illness or injury. Payment will not be made for care and treatment which is not deemed medically necessary.

3. Participating provider office visits are subject to a $10 per visit co-payment. Covered services in the participating provider's office include:

a. laboratory and x-ray services;

b. immunizations for children under age 19;

c. prenatal care visits. Only one co-payment for all visits shall be charged if the participating provider bills in one lump sum;

d. an annual physical exam.

4. Fees for X-ray and laboratory tests made on an outpatient basis for diagnosis or treatment of an illness are covered when ordered by a participating provider. This benefit has a $1,000 calendar year maximum and is subject to the insured paying either $5 co-payment or a maximum of 10 percent of the charge up to a maximum of $1,100 per calendar year. The authorized carrier shall specify which option is to be taken in applying to participate in the LA Health Plan.

5. Surgical and related expenses are covered under the LA Health Plan up to a maximum of $5,000 per insured per calendar year. A $50 per surgical procedure co-payment is required.

6. Maternity care is a covered service subject to the following co-payment requirements:

a. normal vaginal delivery—$50 co-payment;

b. Cesarean delivery—$100 co-payment;

c. if hospitalization follows delivery, the $50 per day inpatient co-payment shall apply.

B. Outpatient mental health care services provided by a provider licensed to diagnose and treat mental and nervous disorders are covered when provided by a participating provider up to a maximum of $1,000 per calendar year with a $10 per visit co-payment.

C. Benefits for the following services are paid subject to the benefits listed in the regulation:

1. use of a participating hospital operating and treatment rooms and equipment;

2. diagnostic X-rays, laboratory procedures and medical diagnostic procedures used to determine the cause of an illness when performed within 14 days prior to participating hospital admission.

D. Benefits shall be provided for mammograms. A $5 per screening co-payment is required when performed by a participating provider and performed with the following frequency:

1. once as a base line mammogram for any female between 35 and 40 years of age;

2. once every two years for any female between 40 and 50 years of age;

3. once every year for any female age 50 or above; and

4. when recommended by a participating provider for a female at risk. Female at risk means a female:

a. who has a personal history of breast cancer;

b. who has a personal history of biopsy proven benign breast disease;

c. whose grandmother, mother, sister, or daughter has had breast cancer; or

d. who has not given birth prior to age 30.

E. Benefits are provided for one pap smear examination per year when performed upon recommendation of a participating provider. A $5 per examination co-payment is required.

F. Benefits are provided for annual prostate antigen tests for covered males who are 45 years of age or older; or covered males who are 40 years of age or older, if ordered by a participating provider. A $5 per test co-payment is required.

G. Benefits are provided for colon cancer screening when ordered by a participating provider. A $5 per screening co-payment is required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3135. Limitations

A. Pre-Existing Conditions

1. Until coverage for an insured enrolled in the LA Health Plan has been in force for 12 consecutive months, benefits for services to be paid to an authorized carrier shall not be available for any illness, injury, or other condition for which:

a. the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or 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 individual insured.

2. Maternity benefits are available to an insured only if the date of conception occurred after the effective date of coverage under the LA Health Plan.

3. No coverage is available to inpatient hospital admissions which begin before an insured's effective date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3137. Exclusions

A. There is no benefit provided for the following:

1. any treatment or care not received from a participating hospital or participating provider;

2. private duty nursing;

3. prescription drugs (outpatient) or over-the-counter medicines. However, outpatient prescriptions may be covered by an additional rider to the LA Health Plan;

4. inpatient treatment or counseling for mental and nervous disorders;

5. care for any condition or injury recognized as a compensable loss through any workers' compensation, occupational disease, or similar law;

6. any disease or injury resulting from a war, declared or not, or resulting from any military duty;

7. any item, service, supply, or care not specifically listed as a benefit under the LA Health Plan;

8. care given by a medical department or clinic run by an insured's employer;

9. hospitalization and related services or care rendered if primarily for diagnostic studies;

10. care of corns, bunions (except capsular or related surgery), callouses, nails of the feet (except surgical removal), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints related to the feet;

11. admission or continued hospital stay for care not medically required on an inpatient basis;

12. skilled nursing care;

13. eyeglasses, contact lenses, hearing aids, hearing devices, or cochlear implants, and related examinations and services;

14. charges for convenience items during a hospital admission;

15. custodial care, rest cures, or travel expenses, even if recommended for health reasons by a physician;

16. care, supplies, or equipment not medically necessary for the treatment of injury or illness;

17. cosmetic or reconstructive surgery except to restore function of any body area which has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes;

18. care prescribed and supervised by other than a participating provider;

19. dental care and treatment by a dentists or a health care provider, including dental surgery, dental appliances, dental prostheses such as crowns, bridges, or dentures; implants, orthodontic care, operative restoration of teeth (fillings); dental extractions (except impacted teeth); endontic care; apicoectomies, treatment of dental caries, gingivitis, or periodontal surgery, vestibuloplasties, alveoloplasties, dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; temporomandibular joint syndrome (TMJ), including related appliances; or other dental procedures. Except for the following treatments which shall be reimbursable at the levels specified in §3133 of this regulation:

a. to correct traumatic injuries which occur while the insured is covered under the LA Health Plan; or

b. to correct congenital defects of a child born under and who remains covered under the LA Health Plan; or

c. for the extraction of impacted teeth after the required waiting period has been met;

20. surgical or medical care for obesity, weight reduction, or dietary control;

21. surgical or medical treatment to modify the sex of an individual or services related to the treatment for impotence or other sexual dysfunctions or inadequacies;

22. professional ambulance service;

23. hair transplants, hair pieces, wigs, wig maintenance, or prescriptions or medications related to hair growth;

24. advice or consultation given by any form of telecommunication;

25. services and supplies which are experimental or investigational in nature;

26. charges for failure to keep a scheduled visit or charges for completion of claim forms; charges for physician or hospital standby services; charges for holiday or overtime rates;

27. outpatient speech, occupational, cardiac rehabilitation, or physical therapy;

28. outpatient use of durable medical equipment;

29. radial keratotomy; and surgery, services, or supplies for the surgical correction of nearsightedness and/or astigmatism;

30. services related to or performed in conjunction with artificial insemination, in vitro fertilization or infertility;

31. biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training and any related diagnostic testing;

32. services for conditions related to austic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation;

33. charges for treatment of a physical injury resulting from suicide or a suicide attempt, sane or insane;

34. intentionally self-inflicted injury;

35. injuries received while committing a crime.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3139. Outpatient Prescription Rider

A. An authorized carrier may offer as rider to the LA Health Plan coverage for outpatient prescription drugs that includes a minimal co-payment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3141. Premium Maximums, Method for Calculating

A. Premiums charged for the LA Health pilot plans shall be based on the average standard rate charged by the five largest health and accident insurers offering individual coverage in the state, as identified by the Louisiana Health Insurance Association's annual survey in accordance to R.S. 22:240.F(3). Annual survey results may be obtained from the department. For the purpose of calculating the maximum premiums as established in §3141.B of this regulation, insurers shall use the premiums identified in the Louisiana Health Insurance Association's Plan "A" and shall use the strict average of male and female rates.

B. Premium rates shall be community rated within each service area, but may vary according to an enrolled individual's status, (i.e., adult or minor dependent and smoker or nonsmoker), as established in §3141.B.1-3 of this regulation.

1. Adult individual rates shall be based on a per unit basis. Each individual's premium rate enrolled in the plan shall be no more than 60 percent of the strict average of the average individual standard rate charges for adults as identified in §3141.A of this regulation.

2. For the purpose of establishing the premium rate for minor dependents, there shall be one rate regardless of the number of minor dependents enrolled under each plan policy. The premium rate for minor dependents shall be no more than 60 percent of the average individual standard charged for children as identified in §3141.A of this regulation.

3. Rates may vary according to an individual's status as either a smoker or nonsmoker. For those individuals enrolled in the plan as a smoker, premium rates identified in §3141 shall be based on the average individual standard rate charged for smokers as identified in §3141. For those individuals enrolled in the plan as a nonsmoker, premium rates identified in §3141 shall be based on the average individual standard rate charge for nonsmokers as identified in §3141.A of this regulation.

4. Where a sliding scale is utilized for setting an individual or family's premium payment amount (including any contribution which may be made by an employer), the maximum payment amount for the highest income level cannot exceed the upper limits established under §3141.B.1-3 of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3143. Payment of Benefits

A. An insured under the LA Health Plan is entitled to benefits for covered services as specified in this regulation and in the contract between an authorized carrier and the insured.

B. Benefits will be provided only if covered services are prescribed by or performed by or under the direct supervision of a participating provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3145. General Provisions

A. All premium payments for coverage are due in advance. Monthly premium payments are for a complete month of coverage. There are no refunds and any cancellations will be effective on the first day of the month for which a premium has not been paid.

B. Any insured under the LA Health Plan may be considered for reinstatement within six months of termination, no matter what the reason prior coverage was terminated.

C. If coverage is terminated due to lack of payments, the insured may reapply for coverage within 90 days and pay any premiums still due.

D. An insured under the LA Health Plan may renew coverage by payment of the necessary premiums to the authorized carrier by the due date.

E. An authorized carrier may change the amount of monthly premium for the LA Health Plan in compliance with the *Insurance Code*. Payment by the insured of the new rate is sufficient to indicate acceptance of the new rate.

F. The LA Health Plan shall be governed by the laws and regulations of the state of Louisiana and specifically those of the LA Health Plan. Nothing in the LA Health Plan shall be construed so as to be in violation of any federal or state law or regulation with the exception of laws specifically preempted by R.S. 22:244-247.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

§3147. Termination of Coverage

A. An insured's spouse who would otherwise lose coverage due to a divorce or death is automatically eligible for coverage in his or her name.

B. Coverage for any child terminates the last day of the month during which such child is no longer eligible for coverage under the LA Health Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:244-247 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:1012 (September 1994).

Chapter 33. Regulation 55—Life Insurance Illustrations

§3301. Purpose

A. The purpose of this regulation is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations for policies not excluded herein. The goals of this regulation are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3303. Applicability and Scope

A. This regulation applies to all group and individual life insurance policies and certificates except:

1. variable life insurance;

2. individual and group annuity contracts;

3. credit life insurance; or

4. life insurance policies with no illustrated death benefits on any individual exceeding $10,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3305. Definitions

A. For the purposes of this regulation:

Actuarial Standards Board—the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

Contract Premium—the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

Currently Payable Scale—a scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next 95 days.

Department—the Louisiana Department of Insurance.

Disciplined Current Scale—a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

a. are consistent with all provisions of this regulation;

b. limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

c. do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

d. do not permit assumed expenses to be less than minimum assumed expenses.

Generic Name—a short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

Guaranteed Elements and Non-Guaranteed Elements—

a. *Guaranteed Elements*—the premiums, benefits, values, credits, or charges under a policy of life insurance that are guaranteed and determined at issue.

b. *Non-Guaranteed Elements*—the premiums, benefits, values, credits, or charges under a policy of life insurance that are not guaranteed or not determined at issue.

Illustrated Scale—a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

a. the disciplined current scale; or

b. the currently payable scale.

Illustration—a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years and that is one of the three types defined below.

a. *Basic Illustration*—a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

b. *In Force Illustration*—an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

c. *Supplemental Illustration*—an illustration furnished in addition to a basic illustration that meets the applicable requirements of this regulation, and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

Illustration Actuary—an actuary meeting the requirements of §3319 who certifies to illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

Lapse-Supported Illustration—an illustration of a policy form failing the test of self-supporting as defined in this regulation, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five years and 100 percent policy persistency thereafter.

Minimum Assumed Expenses—

a. the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

i. fully allocated expenses;

ii. marginal expenses; and

iii. a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the department.

b. Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

Non-Term Group Life—a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

a. every plan of coverage was selected by the employer or other group representative;

b. some portion of the premium is paid by the group or through payroll deduction; and

c. group underwriting or simplified underwriting is used.

Policy Owner—the owner named in the policy or the certificate holder in the case of a group policy.

Premium Outlay—the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

Self-Supporting Illustration—an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the 15 policy anniversary or the 20 policy anniversary for second-or-later-to-die policies (or upon policy expiration, if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3307. Policies to Be Illustrated

A. Each insurer marketing policies to which this regulation is applicable shall notify the department whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on the effective date of this regulation, the insurer shall identify, in writing, those forms and whether or not an illustration will be used with them. For policy forms filed after the effective date of this regulation, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the department.

B. If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

C. If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this regulation is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

D. Potential enrollees of non-term group life subject to this regulation shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this regulation, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3309. General Rules and Prohibitions

A. An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this regulation, be clearly labeled "life insurance illustration" and contain the following basic information:

1. name of insurer;

2. name and business address of producer or insurer's authorized representative, if any;

3. name, age, and sex of proposed insured, except where a composite illustration is permitted under this regulation;

4. underwriting or rating classification upon which the illustration is based;

5. generic name of policy, the company product name, if different, and form number;

6. initial death benefit; and

7. dividend option election or application of non-guaranteed elements, if applicable.

B. When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not:

1. represent the policy as anything other than a life insurance policy;

2. use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

3. state or imply that the payment or amount of non-guaranteed elements is guaranteed;

4. use an illustration that does not comply with the requirements of this regulation;

5. use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

6. provide an applicant with an incomplete illustration;

7. represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

8. use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;

9. except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or

10. use an illustration that is not "self-supporting."

C. If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3311. Standards for Basic Illustrations

A. Format. A basic illustration shall conform with the following requirements.

1. The illustration shall be labeled with the date on which it was prepared.

2. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages").

3. The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

4. If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

5. The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

6. Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

7. If the illustration shows any non-guaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled non-guaranteed.

8. The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page one for guaranteed elements.")

9. The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

10. The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

11. Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

12. Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

a. the benefits and values are not guaranteed;

b. the assumptions on which they are based are subject to change by the insurer; and

c. actual results may be more or less favorable.

13. If the illustration shows that the premium payer may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

14. If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

B. Narrative Summary. A basic illustration shall include the following:

1. a brief description of the policy being illustrated, including a statement that it is a life insurance policy;

2. a brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

3. a brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

4. identification and a brief definition of column headings and key terms used in the illustration; and

5. a statement containing in substance the following:

"This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

C. Numeric Summary

1. Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values

shall be based on the contract premium. This summary shall be shown for at least policy years 5, 10 and 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years 5, 10, 20 and 30:

a. policy guarantees;

b. insurer's illustrated scale;

c. insurer's illustrated scale used but with the non-guaranteed elements reduced as follows:

i. dividends at 50 percent of the dividends contained in the illustrated scale used;

ii. non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

iii. all non-guaranteed charges including, but not limited to, term insurance charges, mortality and expense charges at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

2. In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three bases.

D. Statements. Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this regulation.

1. A statement to be signed and dated by the applicant or policy owner reading as follows:

> "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."

2. A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows:

> "I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

E. Tabular Detail

1. A basic illustration shall include the following for at least each policy year from 1 to 10 and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the twentieth year, for any year in which the premium outlay and contract premium, if applicable, is to change:

a. the premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

b. the corresponding guaranteed death benefit, as provided in the policy; and

c. the corresponding guaranteed value available upon surrender, as provided in the policy.

2. For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

3. Non-guaranteed elements may be shown, if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3313. Standards for Supplemental Illustrations

A. A supplemental illustration may be provided so long as:

1. it is appended to, accompanied by, or preceded by a basic illustration that complies with this regulation;

2. the non-guaranteed elements shown are not more favorable to the policy owner than the corresponding elements, based on the scale used in the basic illustration;

3. it contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed; and

4. for a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

B. The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3315. Delivery of Illustrations and Record Retention

A.1. If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this regulation, shall be submitted to the insurer at the time of policy application. A copy shall also be provided to the applicant.

2. If the policy is issued other than as applied for, a revised basic illustration, conforming to the policy as issued, shall be sent with the policy. The revised illustration shall conform to the requirements of this regulation, shall be

labeled "Revised Illustration" and shall be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

B.1. If no illustration is used by an insurance producer or other authorized representative in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect, in writing, on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy, as issued, will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

2. If the policy is issued, a basic illustration conforming to the policy, as issued, shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

C. If the basic illustration or revised illustration is sent to the applicant or policy owner by mail from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under §3315.C shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

D. A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three years after the policy is no longer in force. A copy need not be retained if no policy is issued.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3317. Annual Report; Notice to Policy Owners

A. In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information.

1. For universal life policies, the report shall include the following:

a. the beginning and ending date of the current report period;

b. the policy value at the end of the previous report period and at the end of the current report period;

c. the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

d. the current death benefit at the end of the current report period on each life covered by the policy;

e. the net cash surrender value of the policy as of the end of the current report period;

f. the amount of outstanding loans, if any, as of the end of the current report period; and

g. for fixed premium policies:

i. if, assuming guaranteed interest, mortality and expense loads, and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

h. for flexible premium policies:

i. if, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

2. For all other policies, where applicable:

a. current death benefit;

b. annual contract premium;

c. current cash surrender value;

d. current dividend;

e. application of current dividend; and

f. amount of outstanding loan.

3. Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

B. If the annual report does not include an in-force illustration, it shall contain the following notice displayed prominently:

> "Important Policy Owner Notice: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address] or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department."
>
> The insurer may vary the sequential order of the methods for obtaining an in force illustration.

C. Upon the request of the policy owner, the insurer shall furnish an in-force illustration of current and future benefits and values based on the insurer's present illustrated scale.

This illustration shall comply with the requirements of §§3309.A.-B and 3311.A and E. No signature or other acknowledgment of receipt of this illustration shall be required.

D. If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3319. Annual Certifications

A. The board of directors of each insurer shall appoint one or more illustration actuaries.

B. The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this regulation.

C. The illustration actuary shall:

1. be a member in good standing of the American Academy of Actuaries;

2. be familiar with the standard of practice regarding life insurance policy illustrations;

3. not have been found by the department, following appropriate notice and hearing, to have:

a. violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

b. been found guilty of fraudulent or dishonest practices;

c. demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

d. resigned or been removed as an illustration actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

4. promptly notify the department of any action taken by a department of another state similar to that under §3319.C.3;

5. disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If non-guaranteed elements illustrated for new policies are not consistent with those illustrated for similar in-force policies, this must be disclosed in the annual certification. If non-guaranteed elements illustrated for both new and in-force policies are not consistent with the nonguaranteed elements actually being paid, charged, or credited to the same or similar forms, this must be disclosed in the annual certification; and

6. disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

a. fully allocated expenses;

b. marginal expenses; or

c. a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the department.

D.1. The illustration actuary shall file a certification with the board and with the department:

a. annually for all policy forms for which illustrations are used; and

b. before a new policy form is illustrated.

2. If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the department promptly.

E. If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the department promptly of his or her inability to certify.

F. A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

1. that the illustration formats meet the requirements of this regulation and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

2. that the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in §3319.C.6.

G. The annual certifications shall be provided to the department each year by a date determined by the insurer.

H. If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the department of that fact promptly and disclose the reason for the change.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3321. Severability

A. If any provision of this regulation, or its application to any person or circumstance, is, for any reason, held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

§3323. Effective Date

A. This regulation shall become effective July 1, 1997 and shall apply to policies sold on or after the effective date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:984 (October 1996).

Chapter 35. Regulation 56—Credit for Reinsurance

§3501. Purpose

A. The purpose of this regulation is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the statutory provisions on Credit for Reinsurance, R.S. Title 22, Sections 941 et seq. The actions and information required by this regulation are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3503. Severability

A. If any provision of item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation which can be given effect without the invalid provisions, item, or application."

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995), amended by Louisiana Legislature, House Concurrent Resolution Number 135 of the 2001 Regular Session, LR 27:1102 (July 2001).

§3505. Credit for Reinsurance—Reinsurer Authorized in this State

A. Pursuant to R.S. 22:941(B), credit shall be allowed when the reinsurance is ceded by a domestic insurer to an assuming insurer which is authorized in this state. An authorized insurer is one which holds a certificate of authority to transact insurance or reinsurance, as of the date of the ceding insurer's quarterly or annual financial statement filed in accordance with R.S.22:1451(D).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3507. Credit for Reinsurance—Accredited Reinsurer

A. Pursuant to R.S.22:941(C), credit shall be allowed when the reinsurance is ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date of the ceding insurer's quarterly or annual financial statement, filed in accordance with R.S.22:1451(D). An accredited reinsurer shall be approved by the Department of Insurance after filing an application for accreditation, and:

1. filing with the Department of Insurance a properly executed Form AR-1 (§3525.B) as evidence of its submission to the jurisdiction of this state; and

2. submission of the reinsurer to the authority of the Department of Insurance to examine books and records of the reinsurer; and

3. demonstration by the reinsurer that the reinsurer is licensed or authorized to transact insurance or reinsurance in, or in the case of a United States branch of an alien assuming insurer, is entered through, at least one state which employs standards regarding credit for reinsurance equal to or exceeding those applicable under §3507.A.3; and

4. annually filing with the Department of Insurance a true copy of its annual statement filed with the insurance department of its state of domicile, or in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recently audited financial statement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3509. Credit for Reinsurance—Reinsurer Maintaining Trust Funds

A. Pursuant to R.S. 22:941(D), credit shall also be allowed when the reinsurance is ceded by a domestic insurer to an assuming insurer which, as of the date of the ceding insurer's quarterly or annual financial statement filed in accordance with R.S.22:1451(D), maintains a trust fund in an amount prescribed below in a qualified United States financial institution as defined in R.S.22:941.2(B), for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall file the Annual Registration for Reinsurers Form and report annually to the commissioner substantially the same information as that required to be reported on the National Association of Insurance Commissioners (NAIC) annual statement form by authorized insurers to enable the commissioner to determine the sufficiency of the trust fund.

B. The following requirements apply to the following categories of assuming insurer.

1. In the case of a single assuming insurer, the trust shall consist of a trusteed account in an amount not less than the assuming insurer's liabilities attributable to business

written in the United States, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million.

2. In the case of a group of insurers that includes individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's aggregate liabilities attributable to business written in the United States, and in addition, the group shall maintain a trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall make available to the commissioner an annual certification of the solvency of each underwriter by its domiciliary regulator and its independent public accountants.

3. In the case of a group of incorporated insurers under common administration, the group shall:

a. submit to this state's authority to examine its books and records and bear the expense of the examination;

b. maintain aggregate policyholders surplus of $10 billion;

c. maintain a trust consisting of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States ceding insurers to any members of the group;

d. in addition, maintain a joint trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for these liabilities;

e. file a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and certify that any member examined will bear the expense of any such examination;

f. within 90 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.

C. Any credit for reinsurance shall not be granted under §3509.A unless the form and amendments to the trust have been approved by the Department of Insurance. The trust instrument shall provide that:

1. contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States;

2. legal title to the assets of the trust shall be vested in the trustees of the trust for its United States ceding insurers, their assigns and successors in interest;

3. the trust shall be subject to examination as determined by the department;

4. the trust shall remain in existence for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under the reinsurance agreements subject to the trust;

5. no later than February 28 of each year the trustees of the trust shall provide a written report to the department setting forth the balance in the trust and listing the investments of the trust of the preceding year, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the succeeding December 31.

D. If the assuming insurer is not authorized or accredited to transact insurance or reinsurance in this state, credit permitted by §3509 shall not be allowed unless:

1. the assuming insurer provides the following in all reinsurance agreements:

a. that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, comply with all requirements necessary to give such court jurisdiction, and abide by the final decision of the district court or appellate court;

b. to designate the commissioner its true and lawful attorney, who may be served any lawful service of process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer;

c. the provisions of §3509.D.1.a-b 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;

d. the assuming insurer files with the department a list identifying its officers and directors (or similar principals), along with biographical information for each, and provides an annual update of this information; and

e. the assuming insurer agrees to allow the department to examine its books and records and to waive any protection it has under any secrecy laws of its domiciliary jurisdiction, except that such examinations will only take place upon the commissioner's showing of good cause for concern about the financial soundness or solvency of the subject entity.

E. The ceding insurer may take credit for the reserves on such ceded risks to the extent reinsured, except that:

1. no credit shall be taken for such reserves unless the insurer accepting the reinsurance meets the requirements set forth in §3509 as valid assuming insurers;

2. no credit shall be allowed to any ceding insurer for reinsurance, as an admitted asset or as a deduction from liability, unless the reinsurance shall be payable, in the event of insolvency of the ceding insurer, to its liquidator or receiver on the basis of the claim or claims allowed against the insolvent ceding insurer by any court of competent

jurisdiction or any justice or judge thereof, or by any receiver or liquidator having authority to determine and allow such claims, except either where the reinsurance contract with the consent of the direct insured or insureds specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer or when the assuming insurer, with the consent of the direct insured or insureds, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees;

3. no credit shall be permitted unless the assuming insurer has been doing business in its country of domicile for at least three years, or is an affiliate of an insurer or reinsurer which has been doing business in its country of domicile for at least three years, unless the department, for good cause shown, waives this three-year operating requirement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3511. Credit for Reinsurance Required by Law

A. Pursuant to R.S.22:941(E), any credit for reinsurance shall also be allowed when the reinsurance is ceded by a domestic insurer to an assuming insurer not meeting the requirements of R.S.22:941(B),(C), or (D), only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in §3511, *jurisdiction* means any state, district, or territory of the United States and any lawful national government.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3513. Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer

A. A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer that fails to satisfy the requirements of R.S. 22:941 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, and such a reduction shall be in the amount of funds held by, or on behalf of, the ceding insurer, including funds held in trust in this state for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in this state subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in R.S. 22:941.2(B). The security may be in the form of:

1. cash;

2. securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners (NAIC) and qualifying as admitted assets;

3. clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States institution, as defined in R.S. 22:941.2(A), effective no later than December 31 in respect of the year for which filing is being made, and in possession of the ceding company on or before the filing date of its annual statement. 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.

B. A reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to §3513.A-C of this regulation shall be allowed only when the requirements of §§3515, 3517, and 3519 of this regulation are met and the assuming insurer has filed the Annual Registration for Reinsurers Form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3515. Trust Agreements Qualified under §3513.

A. As used in §3515:

Beneficiary—the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).

Grantor—the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

Obligations—as used in §3515.B.11, means:

a. reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

b. reserves for reinsured losses reported and outstanding;

c. reserves for reinsured losses incurred but not reported; and

d. reserves for allocated reinsured loss expenses and unearned premiums.

B. Required Conditions

1. The trust agreement shall be entered into between the beneficiary, the grantor, and a trustee which shall be a qualified *United States financial institution*, as defined in Section R.S. 22:941.2(A) of the Act.

2. The trust agreement shall create a trust account into which assets shall be deposited.

3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to §3515. If the commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary, in writing, and the trust agreement must provide that the written notice described in §3515.B.4.a must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.

4. The trust agreement shall provide that:

a. the beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

b. no other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

c. it is not subject to any conditions or qualifications outside of the trust agreement; and

d. it shall not contain references to any other agreements or documents except as provided for under §3515.B.11.

5. The trust agreement shall be established for the sole benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

a. receive assets and hold all assets in a safe place;

b. determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may, whenever necessary, negotiate any such assets, without consent or signature from the grantor or any other person or entity;

c. furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

d. notify the grantor and the beneficiary within 10 days, of any deposits to or withdrawals from the trust account;

e. upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

f. allow no substitutions or withdrawals of assets from the trust account; except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

10. The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct, or lack of good faith.

11. Notwithstanding other provisions of this regulation, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in this regulation, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

a. to pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

b. to make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

c. where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account in the name of the ceding insurer in any qualified United States financial institution, as defined in R.S. 22:941.2(A) of the Act, apart from its general assets, in trust for such uses and purposes specified in §3515.B.11.a-b as may remain executory after such withdrawal and for any period after the termination date.

12. The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by §3515.D.1.b, so long as these required conditions are included in the trust agreement.

C. Permitted Conditions

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice, and that the trustee

may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

2. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive, from time to time, payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in §3515.D.1.b.

4. The trust agreement may provide that the beneficiary may at any time designate a party to whom all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

5. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

D. Additional Conditions Applicable to Reinsurance Agreements

1. A reinsurance agreement which is entered into in conjunction with a trust agreement and the establishment of a trust account may contain provisions that:

a. require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer and specifying what the agreement is to cover;

b. stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by the *Insurance Code*, or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, then the trust agreement may contain the provisions required by §3515.D.1.b in lieu of including such provisions in the reinsurance agreement;

c. require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may, whenever necessary, negotiate these assets without consent or signature from the assuming insurer or any other entity;

d. require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

e. stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law including, without limitation, any liquidator, rehabilitator, receiver, or conservator of such company without diminution because of insolvency on the part of the ceding insurer or the assuming insurer only for the following purposes:

i. to reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

ii. to reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

iii. to fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses, and unearned premium reserves; and

iv. to pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

2. The reinsurance agreement may also contain provisions that:

a. give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

i. the assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

ii. after withdrawal and transfer, the market value of the trust account is no less than 102 percent of the required amount;

The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

b. provide for:

i. the return of any amount withdrawn in excess of the actual amounts required for §3515.D.1.e.i-iii, or in the case of §3515.D.1.e.iv any amounts that are subsequently determined not to be due; and

ii. interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to §3515.D.1.e.iii;

c. permit the award by any arbitration panel or court of competent jurisdiction of:

i. interest at a rate different from that provided in §3515.D.2.b.ii;

ii. court of arbitration costs;

iii. attorney's fees; and

iv. any other reasonable expenses.

3. Financial Reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this regulation when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

4. Existing Agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to September 1, 1995 will continue to be acceptable until August 31, 1996, at which time the agreements will have to be in full compliance with this regulation for the trust agreement to be acceptable.

5. The failure of any trust agreement to specifically identify the beneficiary as defined in §3515.A shall not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3517. Letters of Credit Qualified under §3513

A. The letter of credit must be clean, irrevocable, and unconditional and issued or confirmed by a qualified United States financial institution, as defined in R.S. 22:941.2(A). The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds, and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in §3517.I.1. As used in §3517, *beneficiary* means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).

B. The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

C. The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

D. The term of the letter of credit shall be for at least one year and shall contain an evergreen clause which prevents the expiration of the letter of credit without due notice from the issuer. The evergreen clause shall provide for a period of no less than 30 days notice prior to expiry date or nonrenewal.

E. The letter of credit shall state whether it is subject to and governed by the laws of this state or the latest edition of the *Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce* (Publication 400), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

F. If the letter of credit is made subject to the latest edition of the *Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce* (Publication 400), then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 or the successor to Article 19 in later editions of such publication occur.

G. The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit, pursuant to R.S. 22:941.2(A).

H. If the letter of credit is issued by a qualified United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution, as described in §3517.G, then the following additional requirements shall be met:

1. the issuing qualified United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

2. the evergreen clause shall provide for 30 days notice prior to expiry date for nonrenewal.

I. Reinsurance Agreement Provisions

1. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

a. require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

b. stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer, pursuant to the provisions of the reinsurance agreement, may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

i. to reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

ii. to reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

iii. to fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement (such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves); and

iv. to pay any other amounts the ceding insurer claims are due under the reinsurance agreement;

c. all of the foregoing provisions of §3517.I.1 should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

2. Nothing contained in §3517.I.l shall preclude the ceding insurer and assuming insurer from providing for:

a. an interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to §3517.I.l.b.iii; and/or

b. the return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of §3517.I.l.b.iv, any amounts that are subsequently determined not to be due.

3. When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities, and health where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of §3517.I.l.b, require that the parties enter into a *Trust Agreement* which may be incorporated into the reinsurance agreement or be a separate document.

J. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3519. Other Security

A. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3521. Reinsurance Contract

A. Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of §§3505, 3507, 3509, or 3513 of this regulation or otherwise in compliance with R.S.22:941 after the adoption of this regulation unless the reinsurance agreement:

1. includes a proper insolvency clause pursuant to R.S. 22:941(G)(2); and

2. includes a provision pursuant to R.S.22:941(F)(1) whereby the assuming insurer, if not authorized or accredited, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3523. 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 20 percent of the total amount of its outstanding reserves, not including in either case premiums ceded by agreements made in the ordinary course of business covering the reinsurance of individual risks under reinsurance relating to current business.

B. If the Commissioner of Insurance refuses to approve any such agreement submitted for his approval, he shall grant the insurer a hearing upon request.

C. In addition to the requirements of §3523.A, 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3525. Contracts Affected

A. All new and renewal reinsurance transactions entered into after December 31, 1995 shall conform to the requirements of law and this regulation if credit is to be given to the ceding insurer for such reinsurance.

B. Form AR-1

FORM AR-1
CERTIFICATE OF ASSUMING INSURER

_____ _____
(Name of Officer) (Title of Officer)
of
_____,
(Name of Assuming Insurer)
the assuming insurer under a reinsurance agreement(s) with one or more insurers domiciled in
_____,
(Name of State)
hereby certify that_____
(Name of Assuming Insurer)
("Assuming Insurer"):

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(Ceding Insurer's State of Domicile)
for the adjudication of any issues arising out of the reinsurance agreement(s), agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement(s) to arbitrate their disputes if such an obligation is created in the agreement(s).

2. Designates the insurance commissioner of _____ as its lawful
Ceding Insurer's State of Domicile)
attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement(s) instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the insurance commissioner of _____
(Ceding Insurer's State of Domicile)
to examine its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in _____
(Ceding Insurer's State of Domicile)
reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the insurance commissioner at least once per calendar quarter.

Dated: _____

_____
(Name of Assuming Insurer)

BY: _____
(Name of Officer)

_____
(Title of Officer)

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

Chapter 37. Regulation 57—Life and Health Reinsurance Agreements

§3701. Preamble

A. The Department of Insurance recognizes that insurers possessing a certificate of authority routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus.

B. However, it is improper for an insurer possessing a certificate of authority in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Section 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3703. Scope

A. This regulation shall apply to all domestic life and accident and health insurers and to all other life and accident and health insurers which possess a certificate of authority and which are not subject to a substantially similar regulation in their domiciliary state. This regulation shall also similarly apply to property and casualty insurers which possess a certificate of authority with respect to their accident and health business. This regulation shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Section 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3705. Accounting Requirements

A. No insurer subject to this regulation shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

1. renewal expense allowances provided, or to be provided, to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes, and direct expenses including, but not limited to, billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured;

2. the ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets;

3. the ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

4. the ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded;

5. the reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company;

6. the treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies, for a representative sampling of products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk Categories		
a.	Morbidity	
b.	Mortality	
c.	Lapse	This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.
d.	Credit Quality (C1)	This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.
e.	Reinvestment (C3)	This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.
f.	Disintermediation (C3)	This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

Risk Category +—Significant 0—Insignificant	A	B	C	D	E	F
Health Insurance—other than LTC/LTD*	+	0	+	0	0	0
Health Insurance—LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	0	+	+	+	+	+
* LTC = Long Term Care Insurance LTD = Long Term Disability Insurance						

7.a. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured, and the ceding company does not (other than for the classes of business excepted in §3705.A.7.b either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or

otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

b. Notwithstanding the requirements of §3705.A.7.a, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of such assets:

Health Insurance-LTC/LTD

Traditional Non-Par Permanent

Traditional Par Permanent

Adjustable Premium Permanent

Indeterminate Premium Permanent

Universal Life Fixed Premium
(no lump-in premiums allowed)

i. The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = 2\,(I + CG)$$

$$X + Y - I - CG$$

where:

I is the net investment income;
CG is capital gains less capital losses;
X is the current year cash and invested assets;
Y is the same as X but for the prior year.

8. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.

9. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

10. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

11. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured, and in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

B. Notwithstanding §3705.A, an insurer subject to this regulation may, with the prior approval of the commissioner, take such reserve credit or establish such asset as the commissioner may deem consistent with the *Louisiana Insurance Code* and rules and regulations of the department, including actuarial interpretations or standards adopted by the department.

C.1. Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within 30 days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

2. Any increase in surplus net of federal income tax resulting from arrangements described in §3705.C.1 shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the annual statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance ceded" line, page 4 of the annual statement as earnings emerge from the business reinsured.

a. For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34 percent tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. Six million, eight hundred thousand dollars ($6.8) (34 percent of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

b. At the end of year N+1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66 percent of [$4 million - $1 million - $.5 million] up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and -$1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Section 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3707. Written Agreements

A. No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the

department, unless the agreement, amendment, or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

B. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

C. The reinsurance agreement shall contain provisions which provide that:

1. the agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

2. any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Section 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3709. Existing Agreements

A. Insurers subject to this regulation shall reduce to zero by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this regulation which, under the provisions of this regulation, would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding the effective date of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Section 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

§3711. Effective Date

A. This regulation shall become effective November 20, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Section 2(H), 3 and 947.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 21:1246 (November 1995).

Chapter 39. Regulation 58—Viatical Settlements

§3901. Purposes

A. The purpose of this regulation is to provide for the implementation of licensure of viatical settlement providers, brokers or any person soliciting a viatical settlement contract and to provide for related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3903. Applicability and Scope

A. These regulations shall apply to any person soliciting a viatical settlement contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3905. Definitions

A. For purposes of this regulation:

Person—any natural or artificial entity including but not limited to individuals, partnerships, associations, trusts, or corporations.

Viatical Settlement Broker—a person who, for themselves or for another, offers or advertises the availability of viatical settlements, introduces viators to viatical settlement providers, or offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers for a fee, commission, or other valuable consideration. Viatical settlement broker does not include an attorney, accountant, or financial planner retained to represent the viator whose compensation is not paid by the viatical settlement provider.

Viatical Settlement Contract—a written agreement entered into between a viatical settlement provider and a viator in this state. The agreement shall establish the terms under which the viatical settlement provider will pay compensation or anything of value in return for the policyholder's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

Viatical Settlement Provider—a person who enters into a viatical settlement contract with a viator owning a life insurance policy or a viator who owns or is covered under a group policy insuring the life of a person who has a catastrophic or life-threatening illness or condition. *Viatical settlement provider* shall not include:

a. any bank, savings bank, savings and loan association, credit union, or other licensed lending institution which 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 R.S. 22:644 and Regulation 44 promulgated by the Department of Insurance;

c. any natural person who enters into only one viatical contract in a calendar year.

Viator—the owner of a life insurance policy insuring the life of a person with a catastrophic or life-threatening illness or condition or the certificate holder who enters into an agreement under which the viatical settlement provider will pay compensation or anything of value, which compensation

or value is less that 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 the insurance policy or certificate to the viatical settlement provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3907. License Requirements for Viatical Settlement Providers

A. A viatical settlement provider shall not enter into or solicit a viatical settlement contract without first obtaining a license from the Department of Insurance.

B. The application shall be on a form required by the Department of Insurance and accompanied by a fee of $1,000.

C. All members, officers, and designated employees of a partnership, corporation, or other entity issued a license may act as a viatical settlement provider under the contract.

D. The license may be renewed yearly by payment of a fee of $500 on or before May 1 of each year. Failure to pay the fee within the terms prescribed by the Department of Insurance shall result in the automatic cancellation of the license.

E. The applicant shall provide such information as required on forms prescribed by the Department of Insurance.

F. A viatical settlement provider may operate pursuant to the provisions in this law pending licensure by the Department of Insurance, but in no case shall a provider be allowed to operate without a license following June 1, 1996.

G. The minimum capital requirement shall be $500,000, which may be in the form of a bond or cash or cash equivalents.

H. The Department of Insurance shall have the right to suspend, revoke, or refuse to renew the license of any viatical settlement provider as provided by law.

I. The Department of Insurance shall not deny a license application or suspend, revoke, or refuse to renew the license application or suspend, revoke, or refuse to renew the license of a viatical settlement provider without first conducting a hearing in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3909. License Requirements for Viatical Settlement Brokers

A. A viatical settlement broker shall not enter into or solicit a viatical settlement contract without first obtaining a license from the Department of Insurance.

B. The application shall be on a form required by the Department of Insurance and accompanied by a fee of $50.

C. The license may be renewed yearly by payment of a fee of $50. Failure to pay the renewal fee within the time prescribed shall result in automatic cancellation of the license.

D. Viatical brokers operating in this state shall be licensed by the Department of Insurance as a Louisiana life insurance agent, and appointed by a licensed viatical provider.

E. The applicant shall provide such information as required on forms prescribed by the Department of Insurance.

F. A viatical settlement broker may operate pursuant to the provisions in Part V-B of Chapter 1 of Title 22 of the R.S. of 1950 pending licensure by the Department of Insurance, but in no case shall a broker be allowed to operate without a license following June 1, 1996.

G. The Department of Insurance shall have the right to suspend, revoke or refuse to renew the license of any viatical settlement broker as provided by law.

H. The Department of Insurance shall not deny a license application or suspend, revoke, or refuse to renew the license of a viatical settlement provider without first conducting a hearing in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3911. Approval of Viatical Settlement Contract

A. As provided in R.S. 22:205, the Department of Insurance must approve a viatical settlement contract before it is used in this state. If the viatical settlement contract is disapproved, the Department of Insurance shall notify, in writing, the viatical settlement provider, specifying the reasons for disapproval of the contract form; and it shall thereafter be unlawful for such viatical settlement provider to issue such form in this state. In such notice, the Department of Insurance shall state that a hearing will be granted within 60 days upon written request by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3913. Reporting Requirements

A. On March 1 of each calendar year, each licensed provider shall file with the Department of Insurance an annual statement in addition to the following information for the previous calendar year:

1. for each policy viaticated:

a. date viatical settlement contract entered into;

b. life expectancy of viator at time of contract;

c. names of insurance company and face amount of policy;

d. amount paid by the viatical settlement provider to viaticate the policy; and

e. if the viator has died:

i. date of death; and

ii. total insurance premiums paid by viatical settlement provider to maintain the policy in force;

2. breakdown of applications received, accepted and rejected, by disease category;

3. breakdown of policies viaticated by issuer and policy type;

4. number of secondary market vs. primary market transactions;

5. portfolio size; and

6. source and amount of outside financing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3915. Standards for Evaluation of Reasonable Payments

A. In order to assure that viators receive a reasonable return for viaticating an insurance policy, the following shall be minimum amounts.

Less than 6 months	(80 percent)
At least 6 but less than 12 months	(70 percent)
At least 12 but less than 18 months	(65 percent)
At least 18 but less than 24 months	(60 percent)

B. The percentage may be reduced by 5 percent for viaticating a policy written by an insurer rated less than the highest four categories by A.M. Best, or a comparable rating by another rating agency.

C. The commissioner shall have the discretion to permit a reduction to the minimum percentages set forth in §3915, by up to 10 percent, upon a determination by the Department of Insurance that economic conditions have changed to such an extent that such variance is warranted. The procedure for obtaining such variance is as follows:

1. the percentages will be reviewed annually by the commissioner and a bulletin will be issued not later than November 1 of the current year establishing the new percentages to be in effect for the following calendar year commencing January 1 and continuing through December 31. The commissioner will issue a bulletin stating the details of the revised percentage;

2. the commissioner shall have the discretion to permit variance from the minimum percentages set forth in §3915 upon a determination by the Department of Insurance that a viator's insurance policy is within the contestability period permitted by R.S. 22:172;

3. the commissioner may permit variance from the minimum percentages set forth if the expected premium to be paid by the viatical settlement provider exceeds 5 percent of the face value of the policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

§3917. General Rules

A. With respect to policies containing a provision for double or additional indemnity for accidental death or any other additional death benefits, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a designation, to the estate of the viator, unless otherwise mutually agreed to, in writing, by the viator and viatical settlement provider.

B. Payments of the proceeds pursuant to a viatical settlement shall be made in a lump sum. Retention of a portion of the proceeds pursuant to a viatical settlement by a provider or escrow agent is not permissible.

C. A viatical settlement provider or broker shall not discriminate in the making of viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with dependents and without.

D. A viatical settlement provider or broker shall not pay or offer to pay any finder's fee, commission or other compensation to any viator's physician, attorney, accountant, or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement.

E. Contacts for the purpose of determining the health status of the viator by the viatical provider or broker after the viatical settlement has occurred should be limited to once every three months for viators with a life expectancy of more than one year, and to no more than one per month for viators 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.

F. Viatical settlement providers and brokers shall not solicit investors who could influence the treatment of the illness of the viators whose coverage would be the subject of the investment.

G. Advertising Standards

1. Advertising should be truthful and not misleading by fact or implication.

2. 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.

3. 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 advertiser during the past six months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22, Sections 3 and 210.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:989 (October 1996).

Chapter 41. Regulation 60—Advertising of Life Insurance

§4101. Purpose

A. The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1224 (December 1996).

§4103. Definitions

Advertisement—

1. material designed to create public interest in life insurance or annuities or in an insurer, or in an insurance producer; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy including:

a. printed and published material, audiovisual material, and descriptive literature of an insurer or insurance producer used in direct mail, newspapers, magazines, radio and television scripts, billboards, similar displays, the Internet or any other mass communication media;

b. descriptive literature and sales aids of all kinds, authored by the insurer, its insurance producers, or third parties, issued, distributed, or used by such insurer or insurance producer including, but not limited to, circulars, leaflets, booklets, web pages, depictions, illustrations, and form letters;

c. material used for the recruitment, training, and education of an insurer's insurance producers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy;

d. prepared sales talks, presentations, and material for use by insurance producers.

2. *Advertisement*, for the purpose of these rules shall not include:

a. communications or materials used within an insurer's own organization and not intended for dissemination to the public;

b. communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy;

c. a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

Department or *Department of Insurance*—the Louisiana Department of Insurance.

Determinable Policy Elements—elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable policy elements only, or from both determinable and guaranteed policy elements.

Guaranteed Policy Elements—the premiums, benefits, values, credits or charges under a policy, or elements of formulas used to determine any of these that are guaranteed and determined at issue.

Insurance Producer—a person (as defined in R.S. 22:1212.D) solicits, negotiates, effects, procures, delivers, renews, continues, or binds policies of insurance for risks residing, located, or intended for issuance in this state.

Insurer—includes any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, Fraternal Benefit Society, and any other legal entity which is defined as an insurer in the *Louisiana Insurance Code* or issues life insurance or annuities in this state and is engaged in the advertisement of a policy.

Nonguaranteed Policy Elements—the premiums, credited interest rates (including any bonus) benefits, values, non-interest based credits, charges, or elements that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation. *Policy* includes any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

Policy—includes any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

Pre-Need Funeral Contract or *Prearrangement*—an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1225 (December 1996), amended LR 28:2363 (November 2002).

§4105. Applicability

A. These rules shall apply to any life insurance or annuity advertisement intended for dissemination in this state. In variable contracts where disclosure requirements are established pursuant to federal regulation, this regulation shall be interpreted so as to eliminate conflict with federal regulation.

B. Every insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements of its policies. A system of control shall include regular and routine notification, at least once a year, to producers and others authorized by the insurer to disseminate advertisements of the requirement and procedures for company approval prior to the use of any advertisements that is not furnished by the insurer and that clearly sets forth within the notice the most serious consequence of not obtaining the required prior approval. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer, as well as the producer who created or presented the advertisement, provided the insurer shall not be responsible for advertisements that are published in violation of written procedures or guidelines of the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1225 (December 1996), amended LR 28:2364 (November 2002).

§4107. Form and Content of Advertisements

A. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

B. No advertisement shall use the terms investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings, savings plan, private pension plan, retirement plan or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1225 (December 1996), amended LR 28:2364 (November 2002).

§4109. Disclosure Requirements

A. The information required to be disclosed by these rules 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.

B. No advertisement shall omit material information or use words, phrases, statements, references, or illustrations if such omission or such use has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

C. In the event an advertisement uses *Non-Medical*, *No Medical Examination Required*, or similar terms where issue is not guaranteed, such items shall be accompanied by a further disclosure, of equal prominence and in juxtaposition thereto, to the effect that issuance of the policy may depend upon the answers to the health questions set forth in the application.

D. An advertisement shall not use as the name or title of a life insurance policy any phrase which does not include the words *life insurance* unless accompanied by other language clearly indicating it is life insurance. An advertisement shall not use as the name or title of an annuity contract any phrase that does not include the word *annuity* unless accompanied by other language clearly indicating it is an annuity. An annuity advertisement shall not refer to an annuity as a CD annuity, or deceptively compare an annuity to a certificate of deposit.

E. An advertisement shall prominently describe the type of policy advertised.

F. An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no insurance producer or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the Department of Insurance prior to use.

G. An advertisement for a life insurance policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed. An advertisement of or for a life insurance policy under which the death benefit varies with the length of time the policy has been in force shall accurately describe and clearly call attention to the amount of minimum death benefit under the policy.

H. An advertisement for the types of policies described in §4109.F and G shall not use the words *inexpensive*, *low cost*, or other phrase or words of similar import when such policies are being marketed to persons who are 50 years of age or older, where the policy is guaranteed issue.

I. Premiums

1. An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

2. An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.

3. An advertisement shall not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

4. An advertisement which represents a pure endowment benefit as a profit or return on the premium paid rather than as a policy benefit for which a specific premium is paid is deemed to be deceptive and misleading and is prohibited.

5. An advertisement shall not represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact.

6. An advertisement shall not use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up, to describe a plan using nonguaranteed elements to pay a portion of future premiums.

J. Analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments must be complete and accurate. An advertisement shall not emphasize the investment or tax features of a life insurance policy to such a degree that the advertisement would mislead the purchaser to believe the policy is anything other than life insurance.

K. An advertisement shall not state or imply in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable, or in any manner an incorrect or improper practice.

L. If nonforfeiture values are shown in any advertisement, the values must be shown either for the entire amount of the basic life policy death benefit or for each $1,000 of initial death benefit.

M. 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 being made available with a policy unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

N. No insurance producer may use terms such as *financial planner*, *investment advisor*, *financial consultant*, or *financial counseling* in such a way as to imply that he or she is generally engaged in an advisory business in which compensation is unrelated to sales, unless such actually is the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

O. Nonguaranteed Policy Elements

1. An advertisement shall not utilize or describe nonguaranteed policy elements in a manner which is misleading or has the capacity or tendency to mislead.

2. An advertisement shall not state or imply that the payment or amount of nonguaranteed policy elements is guaranteed. If nonguaranteed policy elements are illustrated, they must be based on the insurer's current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

3. An advertisement that includes any illustrations or statements containing or based upon nonguaranteed elements shall set forth, with equal prominence, comparable illustrations or statements containing or based upon the guaranteed elements.

4. If an advertisement refers to any nonguaranteed policy element, it shall indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way; such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience, the advertisement may indicate any such limitation on the insurer's right.

5. An advertisement shall not refer to dividends as Tax Free or use words of similar import, unless the tax treatment of dividends is fully explained and the nature of the dividend as a return of premium is indicated clearly.

6. An advertisement shall not use or describe determinable policy elements in a manner that is misleading or has the capacity or tendency to mislead.

7. An advertisement may describe determinable policy elements as guaranteed but not determinable at issue. This description should include an explanation of how these elements operate, and their limitations, if any.

8. An advertisement may not state or imply that illustrated dividends under either or both a participating policy or pure endowment will be or can be sufficient at any future time to assure without the future payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains the benefits or coverage provided at that time and the conditions required for that to occur.

P. An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

Q. Testimonials, Appraisals, Analysis, or Endorsements by Third Parties

1. Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective insureds as to the nature or scope of the testimonial, appraisal, analysis or endorsement. In using testimonials, appraisals, or analysis the insurer or insurance producer makes as its own all of the statements contained therein, and such statements are subject to all the provisions of these rules.

2. If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be prominently disclosed in the advertisement.

3. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association, or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the insurer, or receives any payment or other consideration from the insurer for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

4. When an endorsement refers to benefits received under a policy for a specific claim, the claim date, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of five years after the discontinuance of its use or publication.

R. An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

S. Policies Sold to Students

1. The envelope in which insurance solicitation material is contained may be addressed to the parents of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student unless such is a correct and truthful statement.

2. All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming form an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.

3. The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with university, college, school, or other educational or training institution, unless true.

T. Introductory, Initial or Special Offers and Enrollment Periods

1. An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

2. An advertisement shall not state or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

3. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. A reduced initial or first year premium may not be described as constituting free insurance for a period of time. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised.

4. An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than 10

days and not more than 40 days from the date on which such enrollment period is advertised for the first time. This rule applies to all advertising media, e.g., mail, newspapers, radio, television, magazines, and periodicals, by any one insurer or insurance producer. The phrase *Any One Insurer* includes all the affiliated companies of a group of insurance companies under common management or control. This rule does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specified provisions of the Louisiana Insurance Code for group, blanket, or franchise insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this rule shall be applied separately to each sponsoring organization.

U. An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends, or underwriting privileges, unless such is the fact.

V. An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not disparage other insurers, insurance producers, policies, services, or methods of marketing.

W. For individual deferred annuity products or deposit funds, the following shall apply.

1. Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. Such higher interest rates shall not be greater than those currently being credited by the company, unless such higher rates have been publicly declared by the company with an effective date for new issues not more than three months subsequent to the date of declaration.

2. If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it shall also disclose in close proximity thereto, and with equal prominence, the actual relationship between the gross and the net premiums.

3. If any contract does not provide a cash surrender benefit prior to commencement of payment of any annuity benefits, any illustrations or statements concerning such contract shall prominently state that cash surrender benefits are not provided.

4. Any illustrations, depictions or statements containing or based on determinable policy elements shall likewise set forth with equal prominence comparable illustrations, depictions or statements containing or based on guaranteed policy elements.

X. An advertisement of a life insurance policy or annuity that illustrates nonguaranteed values shall only do so in accordance with current applicable state law relative to illustrating such values for life and annuity contracts.

Y. An advertisement for the solicitation or sale of a pre-need funeral contract or prearrangement, as defined in §4103.H, which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

1. the fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement, as defined in §4103.H; and

2. the nature of the relationship among the insurance producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1225 (December 1996), amended LR 28:2364 (November 2002).

§4111. Identity of Insurer

A. The name of the insurer shall be clearly identified in all advertisements, and if any specific individual policy is advertised, it shall be identified either by form number or other appropriate description. If an application is a part of the advertisement, the name of the insurer shall be shown on the application. However, if an advertisement contains a listing of rates or features that is a composite of several different policies or contracts of different insurers, the advertisement shall so state, shall indicate, if applicable, that not all policies or contracts on which the composite is based may be available in all states, and shall provide a rating of the lowest rated insurer and reference the rating agency, but need not identify each insurer. If an advertisement identifies the issuing insurers, insurance issuer ratings need not be stated. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

B. No advertisement shall use any combination of words, symbols, or physical materials which, by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1228 (December 1996), amended LR 28:2365 (November 2002).

§4113. Jurisdictional Licensing and Status of Insurer

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond such limits.

B. An advertisement may state that an insurer or insurance producer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers or insurance producers may not be so licensed.

C. An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by a governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1224 (December 1996).

§4115. Statements about the Insurer

A. An advertisement shall not contain statements, pictures or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation, including but not limited to, placement of insurer's rating in the hierarchy of the rating system cited.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1228 (December 1996), amended LR 28:2366 (November 2002).

§4117. Enforcement Procedures

A. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published, or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise, and group policies, hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertisement. Such file shall be subject to inspection by this department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on the examination of the insurer, whichever is the longer period of time.

B. If the department determines that an advertisement has the capacity or tendency to mislead or deceive the public, the department may require an insurer or insurance producer to submit all or any part of the advertising material for review or approval prior to use.

C. Each insurer subject to the provisions of these rules shall file with this department with its annual statement a certificate of compliance, executed by an authorized officer of the insurer, wherein it is stated that to the best of his knowledge, information, and belief the advertisements which were disseminated by or on behalf of the insurer in this state during the preceding statement year, or during the portion of such year when these rules were in effect, complied, or were made to comply in all respects with the provisions of these rules and the insurance laws of this state, as implemented and interpreted by these rules.

D. In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of Part XXVI, Unfair Trade Practices, of the Louisiana Insurance Code, which regulates the trade practices on the business of insurance by defining and 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1228 (December 1996), amended LR 28:2366 (November 2002).

§4119. Conflict with Other Rules

A. It is not intended that these rules conflict with or supersede any rules currently in force or subsequently adopted in this state governing specific aspect of the sale or replacement of life insurance including, but not limited to, rules dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance, and replacement of life insurance policies. Consequently, no disclosure required under any such rules shall be deemed to be an advertisement within the meaning of these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1224 (December 1996).

§4121. Severability

A. If any Section, term or provision of this rule shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other Section, term or provision of this rule, and the remaining Sections, terms and provisions shall be and remain in full force and effect.

AUTHORITY NOTE: Promulgated in accordance with R.S. Title 22, Section 3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1224 (December 1996).

§4123. Effective Date

A. This revised regulation shall become effective upon final publication in the *Louisiana Register* and shall apply to any life insurance or annuity advertisement intended for dissemination in this state on or after the effective date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 22:1229 (December 1996), amended LR 28:2366 (November 2002).

Chapter 45. Regulation 63—Prohibitions on the Use of Medical Information and Genetic Test Results

§4501. Purpose

A. The purpose of this regulation is to establish the statutory prohibitions on the use of medical information including pregnancy tests, genetic tests and related genetic test information by health insurers, third-party administrators, and insurance agents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1120 (June 1998).

§4503. Authority

A. This regulation is issued pursuant to the authority vested in the Commissioner of Insurance under R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1120 (June 1998).

§4505. Definitions

Collection—obtaining a DNA sample or samples for the purpose of determining inherited or individual characteristics that can be utilized to predict the development of medical conditions in the future. *Collection* shall not mean diagnostic or medical treatment information about an existing medical condition or the prior medical condition of a person applying for or being covered by a health benefit plan.

Compulsory Disclosure—any disclosure of genetic information mandated or required by federal or state law in connection with a judicial, legislative, or administrative proceeding.

DNA—deoxyribonucleic acid including mitochondrial DNA, complementary DNA, as well as any DNA derived from ribonucleic acid (RNA). *DNA* shall not mean any medical procedure or test utilized in the practice of medicine for the purpose of diagnosing or treating a medical illness or health related condition.

Disclose—to convey or to provide access to genetic information to a person other than the individual.

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. For purposes of providing individual or group health care coverage, the term *family* shall not be used to prevent the collection of reasonable medical information about individuals applying for health insurance coverage to perform medical underwriting based on existing or past medical conditions of those persons being insured, except *genetic information* as defined herein.

Family History/Pedigree—the medical history of blood relatives of an individual that is used to predict the possibility of developing a medical condition in the future. The term shall not include the medical history of an insured or applicant for coverage under a health benefit plan.

Genetic Analysis—the process of characterizing genetic information from a human tissue sample and does not include the performance of medical tests, including but not limited to blood tests, in the diagnosis or treatment of a medical condition.

Genetic Characteristic—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. The term shall not apply to identification or disclosure of an individual's gender for the purposes of obtaining or maintaining insurance or establishing insurance rates.

Genetic Information—all information about genes, gene products, inherited characteristics, or family history/pedigree that is expressed in common language. *Genetic information* does not include the medical history of an individual insured or applicant for health care coverage.

Genetic Test—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. The determination of a genetic characteristic shall not include any diagnosis of the presence of disease, disability, or other existing medical condition.

Health Benefit Plan—any health insurance policy, plan, or health maintenance organization subscriber agreement issued for delivery in this state under a valid certificate of authority and does not include life, disability income, or long-term care insurance.

Individual—the source of a human tissue sample from which a DNA sample is extracted or genetic information is characterized.

Individual Identifier—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.

Insurer—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 franchise 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. The term *insurer* does not include any individual or entity that does not hold a valid certificate of authority to issue, for delivery in this state, an insurance policy or plan. A certificate of authority to issue an insurance policy or plan for delivery shall not include a license or certificate to act as a preferred provider organization, insurance agent, or third-party administrator.

Person—all persons other than the individual or authorized agent acting on behalf of 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. This shall not prevent any licensed insurance agent duly authorized to act on behalf of the individual, from completing and submitting health insurance application documents required to apply for coverage under a health policy or plan.

Research—scientific investigation that includes systematic development and testing of hypotheses for the purpose of increasing knowledge.

Storage—retention of a DNA sample or of genetic information for an extended period of time after the initial testing process. The term does not include medical history information about insureds or persons applying for coverage under a health benefit plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1120 (June 1998).

§4507. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all issuers of health care policies or contracts of insurance, or health maintenance organization subscriber agreements issued for delivery in the state of Louisiana. The requirements of this regulation shall not impinge upon the normal practice of medicine or reasonable medical evaluation of an individual's medical history for the purpose of providing or maintaining health insurance coverage. The requirements of this regulation address the use of medical information, including use of genetic tests, and genetic information for the purpose of issuing, renewing, or establishing premiums for health coverage. The provisions of this regulation do 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, or long-term care insurance policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1121 (June 1998).

§4509. Prohibitions on the Use of Pregnancy Test Results

A. Any insurer shall be authorized to request medical information that verifies the pregnancy of an insured or individual applying for coverage under a health benefit plan. The results of any prenatal test, other than the determination of pregnancy, shall not be used as the basis to:

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 insured individual or insured family member in the provision of insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1121 (June 1998).

§4511. Requirements for Release of Genetic Test and Related Medical Information

A. A general authorization for the release of medical records or medical information shall not be construed as an authorization for disclosure of genetic information. No insurer shall seek to obtain genetic information from an insured or applicant or from a DNA sample, without first obtaining written informed consent from the individual or authorized representative. To be valid, an authorization to disclose the results of a genetic test shall:

1. be in writing, signed by the individual and dated on the date of such signature;

2. identify the person permitted to make the disclosure;

3. describe the specific genetic information to be disclosed;

4. identify the person to whom the information is to be disclosed;

5. describe with specificity the purpose for which the disclosure is being made;

6. state the date upon which the authorization will expire, which in no event shall be more than 60 days after the date of the authorization;

7. 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;

8. 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.

B. A copy of the authorization shall be provided to the individual. An individual may revoke or amend the authorization in whole or in part, at any time. In complying with the provisions of this Section, the record holder is responsible for assuring only authorized information is released to insurers with respect to medical records that contain genetic information. The requirements of this Section shall not act to impede or otherwise impinge upon the ability of the patient's attending physician to provide appropriate and medically necessary treatment or diagnosis of a medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1121 (June 1998).

§4513. Prohibitions on the Use of Medical Information and Genetic Test Results

A. No insurer shall require an applicant for coverage under a 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, release genetic test information, or to be subjected to questions relating to the medical conditions of persons not being insured under such policy or plan.

B. All insurers shall, in the application or enrollment information required to be provided by the insurer to each applicant concerning a policy or plan, include a written statement disclosing the rights of the applicant. Such statements shall be printed in 10-point type or greater with a heading in all capital letters that states: YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION. Disclosure statements must be approved by the Department of Insurance as complying with the requirements of R.S. 22:213.7 prior to utilization.

C. The results of any genetic test, including genetic test information, shall not be used as the basis to:

1. 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;

2. cancel or refuse to renew the coverage of an individual or family member under the policy or plan;

3. deny coverage or exclude an individual or family member from coverage under the policy or plan;

4. impose a rider that excludes coverage for certain benefits or services under the policy or plan;

5. establish differentials in premium rates or cost sharing for coverage under the policy or plan;

6. otherwise discriminate against an individual or family member in the provision of insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1122 (June 1998).

§4515. General Provisions

A. 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 because it is confidential;

5. pursuant to newborn screening requirements established by state or federal law;

6. as authorized by federal law for the identification of persons;

7. by the Department of Social Services or by a court having juvenile jurisdiction as set forth in *Children's Code* Article 302 for the purposes of child protection investigations or neglect proceedings.

B. An applicant/insured's genetic information is the property of the applicant/insured. No person shall retain genetic information without first obtaining authorization from the applicant/insured or a duly authorized representative, unless retention is:

1. for the purposes of a criminal or death investigation or criminal or juvenile proceeding;

2. to determine paternity.

C. For purposes of R.S. 22:213.7, any person who acts without proper authorization to collect a DNA sample for analysis, or willfully discloses genetic information without obtaining permission from the individual or patient as required under this regulation, shall be liable to the individual for each such violation in an amount equal to:

1. any actual damages sustained as a result of the unauthorized collection, storage, analysis, or disclosure, or $50,000, whichever is greater;

2. treble damages, in any case where such a violation resulted in profit or monetary gain;

3. 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 R.S. 22:213.7.

D. Any person who, through a request, the use of persuasion, under threat, or under a promise of a reward, willfully induces another to collect, store or analyze a DNA sample in violation; or willfully collects, stores, or analyzes a DNA sample; or willfully discloses genetic information in violation of R.S. 22:213.7 shall be liable to the individual for each such violation in an amount equal to:

1. any actual damages sustained as a result of the collection, analysis, or disclosure, or $100,000, whichever is greater;

2. the costs of the action together with reasonable attorney fees as determined by the court, in the case of a successful action under R.S. 22:213.7.

E. The discrimination against an insured 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, receipt of genetic information, or a prenatal test other than one used for the determination of pregnancy shall be treated as an unfair or deceptive act or practice in the business of insurance under R.S. 22:1214.

F. This regulation shall be effective June 20, 1998.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:10, 22:2014, 22:2002(7), 22:214(22) and (23), 22:213.6, and 22:213.7 of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1122 (June 1998).

Chapter 47. Regulation 64—Vehicle Mechanical Breakdown Insurers Cancellation Provisions

§4701. Purpose

A. The purpose of this regulation is to implement standard cancellation requirements in all vehicle mechanical breakdown contracts, and to ensure that all such contracts (hereafter sometimes referred to as "policies") issued, delivered or used in Louisiana are drafted in a more consistent and streamlined manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998).

§4703. Authority

A. This regulation is promulgated under the authority granted the commissioner by R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998).

§4705. Applicability and Scope

A. This regulation shall apply to all vehicle mechanical breakdown contracts that are in force and to insurers issuing, for delivery or use, vehicle mechanical breakdown contracts in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998).

§4707. Cancellation Standards

A. The following standards shall govern the requirements for the cancellation provisions of vehicle mechanical breakdown contracts.

1. All Mechanical Breakdown Insurance contracts having terms of greater than six months shall be cancelable and refundable upon request of the insured.

2. The refund method to be used shall be the sum of the digits (Rule of 78s) or a refund method that will be more favorable to the insured.

3. The return factor is determined by the number of unused months or the number of unused miles, and shall be based on the full premium (including commissions) paid by the insured.

a. The number of months shall mean the number of months from the effective date of the policy until the expiration date of the policy.

b. The number of miles shall mean the sum of the number of miles on the odometer at the time of purchase and the policy mileage limit.

4. A cancellation fee, not to exceed $50, may be charged, provided such fee is disclosed to the purchaser at the time of policy purchase.

5. The method of refund and any cancellation fee, shall be fully disclosed to the insured at or before the time of policy purchase by having such information printed in the policy form and the policy application, which shall be agreed to in writing, by the insured.

6. In calculating any refund requested by the insured, no deduction shall be allowed for any claim that has been paid under the contract being canceled.

7. If cancellation is requested in writing by the insured within 30 days from the date of purchase, full refund, minus the cancellation fee, if any, shall be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998).

§4709. Failure to Comply

A. In addition to any other penalties provided by the Louisiana Insurance Code relating to the regulation of Vehicle Mechanical Breakdown (VMB) insurers, any VMB insurer found to have violated the requirements of this regulation, may be issued a cease and desist order pursuant to R.S. 22:1810.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998).

§4711. Severability

A. If any provision of item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation which can be given effect without the invalid provisions, item, or application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998), amended by Louisiana Legislature, House Concurrent Resolution Number 135 of the 2001 Regular Session, LR 27:1102 (July 2001).

§4713. Effective Date

A. This regulation shall take effect on June 20, 1998.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1811, R.S. 22:3 and R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 24:1123 (June 1998).

Chapter 49. Regulation 65—Bail Bond Licensing Requirements/Bounty Hunter

§4901. Purpose

A. The purpose of this regulation is to establish guidelines for licensing, for transacting an apprehension or surrender of a principal, prelicensing for applicants and continuing education for licensed agents or solicitors, bail bonds, fines and hearings, definitions and related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:706 (April 1999).

§4903. Definitions

A. The following terms when used in this Chapter shall have the following meanings.

Bail Bond Agent—a person, corporation, or partnership which holds an insurance agent or solicitor license and who is authorized to provide surety in Louisiana, and/or engages in the apprehension and return of persons who are released on bail or who failed to appear at any state of the proceedings to answer the charge before the court in which they may be prosecuted. For purposes of this regulation a bail recovery agent is synonymous with a bail bond agent.

Bail Enforcement—the apprehension or surrender of a principal by a natural person who is released on bail or who has failed to appear at any state of the proceedings to answer the charge before the court in which he may be prosecuted.

Bail Solicitor—an individual who holds an insurance license and is authorized by a duly licensed bail bond agent to solicit contracts of bail bond insurance and engages in bail enforcement, solely on behalf of the licensed bail bond agent.

Commissioner—the Louisiana Commissioner of Insurance.

Department—the Louisiana Department of Insurance.

Insurer—any domestic or foreign insurance corporation or association engaged in the business of insurance or suretyship which has qualified to transact surety or casualty business in this state.

Surrender—as defined by the L.A.-CCRP Article 345.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:707 (April 1999).

§4905. Bail Recovery Agent License Requirements for Louisiana

A. In order to engage, to transact, or assist in the apprehension or surrender of a principal, a person must be a duly licensed bail bond agent or solicitor, pursuant to Part XXIV and Part XXV-A of the Louisiana Insurance Code.

1. Prelicensing

a. On and after May 1, 1999, all persons applying for a bail bond agent or solicitor license must complete eight hours of supervised instruction approved by the department, four hours of which, must be instruction in bail enforcement.

2. Continuing Education Program

a. Persons holding a valid bail bond agent or solicitor license must complete 12 hours of a continuing education program, approved by the department, every two-year licensing period, four hours of which must be instruction in bail enforcement. On or before January 1 of every odd numbered year, all duly licensed bail bond agents hall have completed 12 hours of continuing education described in this Section.

3. On and after May 1, 2000, no person shall engage in the bail bond insurance business, including enforcement and bail recovery activities, unless such person is duly licensed bail bond agent or solicitor pursuant to Part XXIV and Part XXV-A of the Louisiana Insurance Code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:707 (April 1999).

§4907. Bail Recovery Persons License Requirement from Other States

A. Bail recovery persons from other states must be duly authorized to transact bail enforcement or be a licensed bail bond agent in the state where the bond was written and shall act in association with a local bail agent duly licensed by the Louisiana Department of Insurance to transact bail enforcement in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:707 (April 1999).

§4909. Out of State Bail Enforcement Procedure and Notification Requirements

A. In order for a bail recovery person from another state to transact a surrender or apprehension of a principal in Louisiana, the following shall be done.

1. Before conducting surrender or apprehension of a principal, the bail recovery person(s) from other states shall notify the local law enforcement.

2. Bail recovery persons from other states must have in their possession certified copies of material needed to identify the principal. Said materials shall be:

a. a judgement of bond forfeiture or court order of failure to appear and/or certified copy of bond and/or the agent's duly executed copy of the contract;

b. a photograph of the principal; and

c. documentation reflecting that person is duly authorized to transact bail enforcement by the state where the bond was written.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:707 (April 1999).

§4911. In State Bail Enforcement Procedure and Notification Requirement

A. In order to transact a surrender or apprehension of a principal, the following shall be done.

1. Before conducting a surrender or apprehension of a principal, the bail bond agent or solicitor shall notify the local law enforcement in the parish or city where the principal is sought unless exigent circumstances exist.

2. The bail bond agent or solicitor shall be required to wear identifying clothing before transacting a surrender or an apprehension in a private residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:707 (April 1999).

§4913. Prohibited Acts

A. No licensed bail agent or solicitor shall improperly withhold, misappropriate, fail to timely remit premiums and reports of bonds written, or convert to one's own use any monies belonging to principals, sureties and underwriters, or others possessed in the course of the business of insurance.

B. No licensed bail agent or solicitor shall perform bail enforcement in pursuit of any principal released on bail for nonpayment of premium. The surrender of a principal in violation of this Subsection shall entitle the principal to the return of any premium paid.

C. No licensed bail agent or solicitor shall remove or have removed any bail bond power of attorney from the clerk of court or sheriff.

D. No licensed bail agent or solicitor shall transact or engage in the surrender or apprehension of a principal with the assistance of an unlicensed person.

E. No commercial surety shall fail to timely pay bond forfeiture claims that meet the requirements of R.S. 22:658.1.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:708 (April 1999).

§4915. Enforcement of Regulation

A. The commissioner is vested with the authority to enforce this regulation. The department may conduct investigations or request other state, parish or local officials to conduct investigations.

B.1. Violations of this Section are governed by Part XXIV (Qualification and License Requirements for Insurance Agents, Brokers, Surplus Lines Brokers and Solicitors) and XXVI (Unfair Trade Practices) of the Louisiana Insurance Code.

2. The commissioner shall impose penalties, sanctions or fines as delineated in Part XXIV and XXVI of the Louisiana Insurance Code. The commissioner may seek contained herein that results in a public harm.

C. The commissioner may promulgate such rules and regulations as may be deemed necessary for the enforcement of this regulation. The department shall impose penalties, sanctions or fines as delineated in the Louisiana Insurance Code and collect such fines as necessary for the enforcement of such rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:708 (April 1999).

§4917. Effective Date

A. This regulation shall become effective on final publication in the April 1999 *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:7, 22:10, 22:658.1, 22:1065.1, 22:1113, 22:1404.3, 22:1191(B), 22:1211, and 22:1214.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 25:708 (April 1999).

Chapter 51. Regulation 66—Requirements for Officers, Directors, and Trustees of Domestic Regulated Entities

§5101. Purpose

A. The purpose of this regulation is to require that officers, directors and trustees of domestic regulated entities, as defined herein, file biographical information with the Commissioner of Insurance for review. The purpose of this review is to determine whether a domestic regulated entity continues to meet minimum licensing standards upon a change in officers, directors or trustees.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:78 (January 1999).

§5103. Definitions

A. For the purpose of this regulation the following definitions shall be applicable.

Director—persons designated in the articles of incorporation, by-laws or other organizational documents as such, and persons designated, elected or appointed by any other name or title to act as directors, and their successors.

Domestic Regulated Entity—any Louisiana domiciled entity which is required to obtain a license or certificate of authority from or register with the commissioner. This definition shall specifically include, but is not limited to, stock and mutual insurers, domestic service insurers, non-profit funeral service associations, reciprocal insurers, Lloyd's plans, fraternal benefit societies, automobile service clubs, vehicle mechanical breakdown insurers, property residual value insurers, animal insurers, health maintenance organizations, non-profit beneficiary organizations and risk indemnification trusts, third party administrators, interlocal risk management agencies or any plan of self insurance providing health and accident or workers compensation coverage to employees of two or more employers.

a. This term shall not include insurance agents, agencies, managing general agents, viatical settlement brokers or reinsurance intermediary brokers.

Officer—a president, vice-president, treasurer, actuary, secretary, controller, partner and any other person who performs for the domestic regulated entity functions corresponding to those performed by the foregoing officers. *Officer* shall also include the administrator of a plan of self-insurance providing health and accident or worker compensation coverage to employees of two or more employers.

Trustee—the trustee of a trust, which provides health and accident or workers compensation coverage to employees of two or more employers.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:78 (January 1999).

§5105. Review of Officers, Directors and Trustees by Commissioner Required

A. No person shall serve as an officer, director or trustee of a domestic insurer who has not first submitted the information required by §5107 to the commissioner or to whom, after review of the information required by §5107, the commissioner has refused to issue a letter of no objection.

B. No domestic regulated entity may elect, appoint or otherwise accept an officer, director or trustee an individual who has failed to submit the information required by §5107 to the commissioner or to whom, after review of the information required by §5107, the commissioner has refused to issue a letter of no objection.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:78 (January 1999).

§5107. Procedure for Requesting Letter of No Objection from Commissioner

A. Each person elected, appointed or who otherwise becomes as an officer, director or trustee of a domestic regulated entity shall, within 30 days of being elected, appointed or otherwise chosen, submit to the commissioner a request for a letter of no objection regarding his service in that capacity. The request shall be made, in writing, on forms provided by the commissioner.

B. Each request for a letter of no objection shall include:

1. such biographical information as the commissioner shall reasonably require to determine compliance with this regulation and the applicable statutes;

2. a statement from the domestic regulated entity indicating the position for which the individual has been elected, appointed or otherwise chosen;

3. a sworn statement from the individual confirming that he has no conflict of interest which would interfere with his service in the position;

4. a copy of the acceptance of trust, oath of office or other such document signed by the individual. The form of this document will be provided by the commissioner and shall include a statement that the individual agrees to abide by and direct the activities of the domestic insurer in compliance with all applicable provisions of the Louisiana Revised Statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:79 (January 1999).

§5109. Conditions for Refusal of Letter of No Objection

A. The commissioner may refuse to issue a letter of no objection if he finds that:

1. the competence, experience and integrity of the individual is such that it would not be in the best interest of policyholders, members or clients of the domestic regulated entity or of the public to allow the person to serve in the proposed position;

2. the individual has been convicted of or has pled nolo contendre to or participated in a pretrial diversion program pursuant to any charge of any felony or misdemeanor involving moral turpitude or public corruption;

3. the individual knowingly makes a materially false statement or omission of material information in the request for a letter of no objection;

4. for any other reason now or hereinafter as the law may provide.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:79 (January 1999).

§5111. Waiver of Submission of Biographical Information

A. The commissioner may waive the requirement that an individual submit biographical information under the following conditions.

1. The individual has served as an officer, director or trustee of a domestic regulated entity for a period of five consecutive years.

2. The individual has received a letter of no objection from the commissioner within one year of being elected, appointed or otherwise chosen as an officer, director or trustee and no material change has occurred in the biographical information submitted in support of that request.

3. Individuals who qualify for a waiver of the submission of the biographical information must submit the document required by §5107.B.4.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:79 (January 1999).

§5113. Scope and Limitations

A. On its effective date, January 20, 1999, this regulation shall apply to all individuals serving as an officer, director or trustee of a domestic regulated entity and to all individuals nominated or otherwise suggested for such positions.

AUTHORITY NOTE: Promulgated in accordance with R.S. (L.R.S.) Title 22, Sections 3, 1770, 1811, 1911, 1942, 2014, 3017(B), 1348(B) 1358(B); Title 23, Section 1200.1 and Title 33, Sections 1348(B) and 1358(B).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:79 (January 1999).

Chapter 53. Regulation 62—Managed Care Contracting Requirements

§5301. Purpose

A. The purpose of this regulation is to establish the reasonable authority and obligation of managed care organizations related to provider contracts under Acts 1485 and 897 of the 1997 Regular Session of the Louisiana Legislature. The provisions of R.S. 40:1300.125 and R.S. 40:1300.145 establish the legislative intent for qualifying rural hospitals, and their practicing physicians, to be allowed to participate in the health care delivery systems of managed care organizations. These statutes also establish the intent of the legislature that managed care organizations provide reasonable reimbursement for the services provided by qualifying rural hospitals and the physicians who practice at these hospitals.

B. Act 897 of the 1997 Regular Session of the Louisiana Legislature amends Titles 40 and 22 of the Louisiana Revised Statutes to prohibit managed care organizations from using incentive arrangements that impede, impair, or otherwise diminish the ability of a plan member or enrollee to receive appropriate and necessary medical care and treatment. These statutes also establish the legislative intent that any prohibitions on the authority of an insurer to contract for delivery of health benefits through capitation or shared risk arrangements be limited to non-compliant incentive arrangements. To carry out the intent of the legislation and assure full compliance with the provisions of these Acts, this regulation establishes reasonable contracting requirements that are applicable to managed care organizations and assures uniformity in application of terms and conditions for participation.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1853 (October 1999).

§5303. Definitions

Accreditation/Certification—a hospital that is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or Medicare certified for provision of acute care hospital services.

Community—the parish in which a qualifying rural hospital is located.

Discriminate—to apply a payment methodology that relies upon terms and conditions that are more restrictive than those terms and conditions applicable to non-rural hospitals or their practicing physicians in a region which result unreasonable payment to a qualifying rural hospital or

physician practicing in such hospitals. A payment methodology that results in reimbursement to a qualifying rural hospital or practicing physician that is equal to or greater than the reimbursement to non-rural participating hospitals or physicians in the region, shall be considered non-discriminating.

Employee—a person employed directly by a managed care organization and does not include any contract, temporary, or other type of employment arrangement.

Geographic Area—a parish.

Health Benefit Plan—any health insurance policy, plan, or health maintenance organization subscriber agreement, issued for delivery in this state under a valid certificate of authority by an entity authorized by law to bear risk for the payment of health care services.

Health Care Provider—a physician duly licensed to practice medicine by the Louisiana State Board of Medical Examiners, or other health care professional duly licensed in Louisiana, or an acute care hospital licensed to provide medical care in this state. The term shall also mean any legal entity or organization formed for the primary purpose of providing medical or health care services and provides such services directly or through its participants.

Incentive Arrangement—any payment or contractual obligation included in a general payment plan, capitation contract, shared risk arrangement, or other agreement between a managed care organization and a health care provider that is tied to utilization of covered benefits.

Managed Care Organization—a health maintenance organization or other entity authorized by law to bear risk for the payment of health care services that holds a valid certificate of authority to issue for delivery in this state a health benefit plan.

Pass Through Payments—any funds or payments received by a managed care organization for the purpose of reimbursing the cost of services provided by a health care provider, that are not covered by the health care provider's contract, including but not limited to research grants, and federal payments for indigent care.

Payment Differential—a difference in the amount paid to a health care provider resulting from negotiations to establish a capitation, risk sharing, or other payment arrangement that is based on financial incentives necessary to establish medical services within a geographic area of the state.

Practicing—a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners who has established his/her practice in the geographic area where the rural hospital is located, maintains active hospital staff privileges, and provides medical treatment in said hospital on a weekly basis. The term shall also include any physician whose participation is essential to provision of services covered under a rural hospital's contract with a managed care organization or treatment of enrollees admitted to the hospital, provided such services are appropriate and within the scope of the hospital's accreditation/certification. The term does not include physicians who are merely affiliated, or associated with a rural hospital or any physician whose participation is essential to treatment of enrollees admitted to the hospital based on the unreasonable refusal of a hospital to utilize another physician available through the managed care organization who is qualified to provide the needed medical services to the patient.

Region—a group of parishes designated by a managed care organization for establishing reimbursement amounts for payment of practicing health care providers. A managed care organization may follow congressional districts or such other reasonable grouping of contiguous parishes in establishing regions. In establishing regions, a managed care organization shall include all parishes of the state and limit the total number of regions to seven. In no event shall any regional configuration be established that acts to discriminate unfairly against qualifying rural hospitals or their practicing physicians.

Rural Hospital—a hospital qualifying to participate in a Health Maintenance Organization under the requirements of Part L of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1300.115.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1853 (October 1999).

§5305. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all managed care organizations holding valid certificates of authority to issue for delivery in this state, an insurance policy, plan, or health maintenance organization subscriber agreement. This regulation addresses the requirements of R.S. 40:1300.115 regarding contracts with rural hospitals and their practicing physicians and establishes standards for participation in a managed care organization. The provisions of this regulation require managed care organizations to provide covered medical benefits either directly, or through contractual agreements with health care providers. A contractual agreement between a managed care organization and a health care provider shall require the health care provider to either:

1. provide covered medical services directly; or

2. in conjunction with other health care providers who are required, under contract or other arrangement, to meet the same statutory and regulatory requirements applicable to health maintenance organization contracts with health care providers.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1854 (October 1999).

§5307. Provider Contracting Requirements

A. R.S. 40:1300.115 requires managed care organizations to accept qualifying rural hospitals, and their practicing physicians who meet specific statutory criteria, as providers of health care subject to the terms and conditions that are no more restrictive than applicable to other hospitals. This requirement applies in every parish where a managed care organization holding a valid certificate of authority issued by the Louisiana Department of Insurance, has policies, subscriber agreements, or contracts for delivery of benefits in effect. R.S. 22:2016.E. requires all hospitals and health care providers utilized by health maintenance organizations to be licensed under applicable state law. R.S. 22:2021 prohibits health maintenance organizations from adopting or utilizing administrative treatment guidelines that fall below the appropriate standard of care. Additionally, R.S. 22:2019 prohibits the utilization of a certificate of authority by any person other than the organization or entity issued said certificate.

1. All contracts for delivery of covered medical services shall be between the managed care organization and a health care provider, except contracts with other insurers for provision of health coverage. A managed care organization is only authorized to contract for delivery of health care services with one or more health care providers. Contracts with brokers, agents, or any entity other than a health care provider for the provision of covered medical services are prohibited. A managed care organization may allow health care providers to utilize other health care providers under contract with the managed care organization.

2. A managed care organization shall limit the medical services included under a health care provider contract to those for which the health care provider is qualified and reasonably capable of providing.

3. A managed care organization shall not adopt or utilize payment standards for health care providers that:

a. require or induce by incentive or payment, the delivery of inappropriate medical care or treatment services;

b. allow the provision of inappropriate or unnecessary medical procedures or treatment services;

c. allow health care providers to perform, for payment, medical or treatment services for which they are not qualified;

d. include an incentive or specific payment made directly or indirectly, in any form, to a health care provider 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.

4. In any review of the terms and conditions of a health care provider's contract conducted by the Department of Insurance, the contract shall not be subject to disclosure to any other health care provider without the expressed written consent of the parties to such contract, except as otherwise allowed by law.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1854 (October 1999).

§5309. Requirements for Inclusion of Rural Hospitals

A. Managed Care Organizations Utilizing a Staff Model Approach

1. Any managed care organization that directly provides health care services to insureds exclusively through its employees and wholly owned facilities that are duly licensed to provide such health care services, are not required to contract with qualifying rural hospitals except:

a. in any geographic area where the managed care organization has insufficient staff and/or facilities to provide the plan of benefits to insureds;

b. for health care services available in the insureds community that are not readily accessible through the managed care organization within a reasonable distance of the community;

c. for other covered services available in the insureds community that are not readily accessible through the managed care organization within a reasonable distance of the community;

d. in a geographic area where the managed care organization utilizes public or private staff or hospitals to furnish health care services.

B. General Managed Care Organization Requirements. A qualifying rural hospital shall be allowed to contract for provision of medical services to insureds or enrollees of a managed care organization who reside in the community where the hospital is located, and can reasonably be expected to utilize the hospital for provision of one or more medical services included in the contract. A qualifying rural hospital shall also be allowed to contract for provision of medical services to other insureds or enrollees of a managed care organization, if the qualifying hospital is located in a parish that is serviced by such managed care organization. The terms and conditions for participation by a qualifying rural hospital shall be no more restrictive than those normally applied to other participating hospitals in the region of the state where the rural hospital is located. Where the managed care organization offers the majority of participating hospitals a choice in contracting on a capitated or non-capitated basis, the same choice shall be available to qualifying rural hospital. In no event shall a managed care organization be required to make any special, enhanced, or extraordinary payment to a qualifying rural hospital based on its rural designation other than pass through payments. Additionally, a managed care organization is expressly prohibited from applying any factor, weight, or other adjustment that acts to reduce payment for medical services provided by a qualifying rural hospital based on its designation as a rural hospital.

C. Capitation Contracting Requirements

1. In establishment of capitation based pricing mechanisms or risk sharing arrangements, a managed care organization is authorized to use reasonable criteria that includes the scope of services available at the hospital and patient volume. A managed care organization may consider the amount and scope of services being included under such contractual arrangements in negotiating reimbursement amounts. However, in no instance shall a managed care organization base reimbursement on the exclusion of one or more qualifying rural hospitals or otherwise limiting enrollee access to appropriate medical care from such hospitals that are located in the community where the enrollee or plan member resides.

2. A managed care organization shall be authorized to use payment differentials to establish a network of providers in a geographic area. A managed care organization shall be authorized to exclude application of such payment differentials to a qualifying rural hospital unless such payment differentials are being offered to other hospitals in the same geographic area. In no instance shall a managed care organization be prohibited from offering payment differentials to a qualifying rural hospital to gain access to health care providers in a geographic area.

D. Other Contracting Requirements. Managed care organizations shall not discriminate against qualifying rural hospitals in establishing or utilizing pricing mechanisms. In no event shall a managed care organization establish payment rates or reimbursement systems that discriminate on the basis of a hospital's designation as a qualifying rural hospital. Modifiers, outliers, or weighting factors applicable to payments made to such qualifying rural hospitals on the basis of diagnosis, diagnosis for related groups (DRGs), procedure, procedure code, per diem, length of stay, or services rendered, shall not discriminate against qualifying rural hospitals, or be used to prevent participation by such hospitals or have this effect.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1855 (October 1999).

§5311. Requirements for Inclusion of Physicians Practicing in Qualifying Rural Hospitals

A. General Managed Care Organization Requirements. A physician licensed to practice medicine by the Louisiana Board of State Medical Examiners, practicing in a qualifying rural hospital that has a health care provider contract with a managed care organization for provision of hospital services included under its accreditation/certification, shall be allowed to enter into a health care provider contract for provision of medical services to insureds or enrollees of the plan, policy, or subscriber agreement. The terms of the health care provider contract shall be no more restrictive than the terms and conditions offered to other health care providers who deliver the same services or benefits to insureds or enrollees of the managed care organization in the state, or applicable region of the state where the physician participates in a qualifying rural hospital. Where the managed care organization offers the majority of participating physicians a choice in contracting on a capitated or non-capitated basis, the same choice shall be available to a physician practicing in qualifying rural hospital. In no event shall a managed care organization be required to make any special, enhanced, or extraordinary payment to a physician practicing in a qualifying rural hospital based on the rural designation of the physician's practice. Additionally, a managed care organization is expressly prohibited from applying any factor, weight, or other adjustment that acts to reduce payment for medical services provided by a physician practicing in a qualifying rural hospital based on the rural designation of the physician's practice.

B. Capitation Contracting Requirements

1. In establishment of capitation based pricing mechanisms or risk sharing arrangements, a managed care organization is authorized to use reasonable criteria that includes the scope of services available from the physician and patient volume. A managed care organization may consider the amount and scope of services being included under such contractual arrangements in negotiating reimbursement amounts.

2. A managed care organization shall be authorized to use payment differentials to gain access to physicians in a geographic area. A managed care organization shall not be required to include in a health care provider contract, any amount that can be reasonably documented as resulting from application of a payment differential that is not applicable to the majority of participating physicians within a geographic area of the state who provide the same services to plan members.

C. Other Contracting Requirements. Managed care organizations shall not discriminate against physicians practicing in qualifying rural hospitals in establishing or utilizing pricing mechanisms. In no event shall a managed care organization establish payment rates or reimbursement systems that discriminate on the basis of a physician's designation as a practicing physician in a qualifying rural hospital or have that effect.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1855 (October 1999).

§5313. General Provisions

A. No health care provider contract entered into by a managed care organization shall include any provision or requirement that directly, or indirectly acts to transfer the organization's certificate of authority. A managed care organization shall not be relieved from performance of all required obligations under Title 22 of the Louisiana Revised Statutes of 1950 by any contract or agreement with a health care provider.

B. Managed care organizations shall assure that all contracts issued on or after July 1, 1998 are in full compliance with the requirements of this regulation. All other contracts shall be brought into compliance upon renewal, amendment, or revision, but in no event later than December 31, 1999.

C. Qualifying rural hospitals and their practicing physicians shall be subject to the same administrative procedures and remedies as any other complainant who files a valid complaint with the Department of Insurance. Managed care organizations found to be violating the requirements of this regulation shall be considered to be engaging in unfair trade practices as defined under R.S. §1214(12). All administrative remedies for any aggrieved party shall be governed by the provisions of Part XXIX of Chapter 1, of Title 22 of the Louisiana Revised Statutes of 1950 comprised of §§1351-1367.

AUTHORITY NOTE: Adopted in accordance with R.S. 22, R.S. 22:3, R.S. 22:215.18, 22:2006, 22:2014, 22:2018, 22:2019, 22:2021 and 22:2022.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1856 (October 1999).

Chapter 55. Regulation 9—Deferred Payment of Fire Premiums in Connection with the Term Rule

§5501. Payment of Fire Premiums

A. To All Insurers Writing Fire Insurance in Louisiana

1. The Fire Insurance Division, Louisiana Insurance Rating Commission, has approved a filing of the Louisiana Fire Prevention Bureau, relative to deferred payment of fire premiums in connection with the term rule. The filing, as approved by the division, is effective April 15, 1955, and reads as follows:

"Rule Number 19-A., Premium Payment Plan

a. Policies covering property eligible to be insured for a term of years under the term rule may be written for a term of three or five years, providing for deferred payment of premium only at the following multiples of the annual rate, with premium payments due as designated, subject to the attachment of Premium Payment Plan Form Number 141 or other evidence, or evidences, of indebtedness. Such other evidence, or evidences, of indebtedness are permitted only provided the amounts and due dates of the several payment are the same as directed below for deferred payments of premiums. Copies of any such evidences of indebtedness shall be attached to the policy and to the daily report for audit.

i. Three Years—2.6 Times Annual Rate. One full annual premium payable at inception; the remainder to be paid one-half within one year after inception and one-half within two years after inception.

ii. Five Years—4.2 Times Annual Rate. One full annual premium payable at inception; the remainder to be paid one-fourth within one year after inception, one-fourth within two years after inception, one-fourth within three years after inception and one-fourth within four years after inception.

NOTE 1: Endorsements to Premium Payment Plan contracts involving additional or return premiums may be handled as cash transactions provided the amount involved does not exceed $5 per remaining unpaid installment, thereby eliminating the necessity of changing the amount of future installments.

NOTE 2: Minimum Premium rules apply separately to each payment required under the above Plan."

2. All companies writing fire insurance in Louisiana are reminded that one of the conditions of their authority to do business in this state is adherence to the rates fixed in accordance with the Insurance Code. Failure to adhere to the above quoted rule of the Fire Division will be regarded as a violation of that condition and companies guilty of such violation may expect that all applicable provisions of the Insurance Code will be invoked.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, April 4, 1955.

Chapter 57. Regulation 14—Limiting Exclusions in Industrial Policies, Restricting Payments for Death Caused in Specified Manner

§5701. Payment of Death or Funeral Benefits

A. All Domestic Insurance Companies

1. If your industrial life insurance or funeral benefit policies contain provisions which exclude or limit the payment of death or funeral benefits because death is caused in any specified manner, or occurs while the insured has a specified status, except those listed below, then it will be necessary that you amend such policies before they are issued.

2. 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 non-combatants 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 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.

3. In the event of death to which there is an exclusion or restriction pursuant to §5701.A.2.a, b, c, d, or e of this provision, the insurer shall pay an amount not less than the reserve on the policy, together with the reserve for any paid-

up additions thereto and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued.

4. In the event of death as to which there is an exclusion or restriction pursuant to Subparagraph (b) of Paragraph (3)(B), the insurer shall pay the greater of:

a. the amount specified in the preceding paragraph; or

b. the amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

5. None of the provisions of §5701.A.5 shall apply to policies issued under Sections 253 and 162.E, nor to any accidental benefits in the event such death by accident or accidental means included in a life policy.

B. Senate Committee Amendment Number 3

1. The Legislative intent of this Amendment, as evidenced by Industry and Committee hearings, was that it should apply only to the two immediately preceding unnumbered paragraphs so that a reduction not to exceed the percentages of the reserve, computed in accordance with Part 5 of the Code, could continue to be taken on funeral policies. Note reference to Sections 253 and 162.E.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:259.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 24, 1958.

§5703. Rider or Endorsement

A. We believe that these policies can be made acceptable more easily by the use of a rider or endorsement. For your guidance, we have reproduced below a form of rider or endorsement which will accomplish the purpose.

> NOTE: The language which we have suggested is not intended to preclude your substituting any appropriate language which is substantially similar in context.

B. If the language of the rider or endorsement which you intend to use is identical with that suggested, you may issue policies, already approved, containing such rider or endorsement, before sending them to this department for approval. Provided, however, that such rider or endorsement must be sent for approval within 30 days of the date of this Directive, and provided further, that if the language suggested is not used, then prior approval must be obtained before policies may be issued.

C. Suggested Rider

> "Attached to and Made Part of Policy No. _____
>
> Any provision in this policy which excludes or restricts coverage in the event of death for any reason, except death occurring:
>
> 1. as a result of war, declared or undeclared, under conditions specified in the policy;
>
> 2. while in:
>
> a. the military, naval or air forces of any country at war, declared or undeclared; or
>
> b. any ambulance, medical, hospital or civilian non-combatant 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 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, is null and void.
>
> If this policy contains a provision for additional benefit in event of death by accidental means, the conditions and exceptions contained therein shall not be affected by this rider.
>
> In witness whereof, the Company has issued this policy rider effective with the date thereof."

D. It is directed that when present supplies of policies to which this rider is attached have been exhausted, that complete policies, containing all the provisions of the contract, including those provisions contained in the rider, will be sent to this department for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:259.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 24, 1958.

Chapter 60. Regulation 74—Payment of Health Coverage Claims

§6001. Purpose

A. The purpose of this regulation is to implement the statutory requirements of health insurance issuers under Title 22 of the Louisiana Revised Statutes of 1950. Title 22 of the Louisiana Revised Statutes of 1950 establishes the statutory requirements for payment of claims by health insurance issuers serving residents of Louisiana. The statutory requirements establish the intent of the legislature to assure that residents with health care coverage are not billed for liabilities of health insurance.

B. To carry out the intent of the legislature and assure full compliance with the provisions of applicable statutory requirements, this regulation sets forth the standards for payment of claims by health insurance issuers and supercedes current regulations on uniform claim forms.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2006 (September 2000).

§6003. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all health insurance coverage issued for delivery in the state of Louisiana that is otherwise subject to the statutory requirements of Part VI-D of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950. The requirements of this regulation apply to all

preferred provider organization contracts as required under the provisions of R.S. 40:2203.1(E) of the Louisiana Revised Statutes of 1950. The requirements of this regulation shall also apply to the State Employees Group Benefits Program as required under R.S. 22:230.4(A)(4).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2006 (September 2000).

§6005. Claim Payments—Definitions

Claim—a request that covered benefits of a health insurance issuer be provided or paid for services that have been provided. The benefits claimed may be in the form of covered services, supplies, payment for all or a portion, of expenses incurred a combination of covered services, supplies and expenses incurred, or indemnification for all or a portion of actual losses.

Claimant—covered person, an authorized representative, or other entity filing a clean claim that is entitled to receive reimbursement from a health insurance issuer for covered benefits.

Clean Claim—a correctly completed standardized claim form as required under the Department of Insurance, Regulation 48.

Commissioner—the Commissioner of Insurance.

Contracted Medical Services—services provided by 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. 40:2203.1 that have entered into a contract or agreement with a health insurance issuer to provide such services, treatment or supplies to an individual enrollee or insured.

Covered Benefits—benefits available to a member, subscriber or insured under an insurance policy, benefit plan, or other contract for coverage of health care benefits. The term also includes any medical services or equipment that is provided to a covered person under an assignment of benefits, when such assignment is authorized by law and the terms of an insurance policy or contract of coverage issued by a health insurance issuer.

Covered Person—an insured, enrollee, member, or subscriber. In the case of a minor, the term includes an insured or legal guardian authorized to act in the best interest of such minor and therefore is acting on behalf of such covered person.

Date Upon Which a Clean Claim is Received—the date the uniform claim form is received by the health insurance issuer or its legal agent. For health insurance issuer examinations, the department will use the postmark date of claims to determine if the date of receipt reasonably reflects the date claims are actually received by health insurance issuers.

Department—the Department of Insurance.

Electronic Claim—the transmission of data for purposes of payment of covered medical services in an electronic data format specified by a health insurance issuer and approved by the department.

Health Insurance Coverage—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 agreement, or health maintenance organization contract offered by a health insurance issuer that is subject to the requirements of Part VI-C of Chapter 1 of the Louisiana Revised Statutes of 1950.

Health Insurance Issuer—an insurance company, including a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of Title 22, unless preempted as an employee benefit plan covered by the provisions of the Employee Retirement Income Security Act of 1974. The term shall also include the State Employees Group Benefits Program as required under R.S. 22:230.4(A)(4) and preferred provider organizations as required under R.S. 40:2203.

Just and Reasonable Grounds Such as Would Put a Reasonable and Prudent Businessman on His Guard—an articulable set of facts, as opposed to mere speculation or assumption, that fully complies with established jurisprudence. For health insurance issuer examinations, the department will reasonably determine whether denials are based on an articulable set of facts.

Non-Contracted Medical Services—services provided by a state-licensed, certified, or state-registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in R.S. 40:1299.41(A)(1) that have no contract or agreement with a health insurance issuer to provide such services, treatment or supplies to an individual enrollee or insured.

Paid—the date the claim is adjudicated and any amount due and payable is released by the health insurance issuer. Any difference between the date of adjudication and the date the payment is released is required to be documented in the health insurance issuer's claim handling procedures filed with the department.

Prohibited Billing Activities—the demand for payment of medical services from a covered person for covered benefits that are payable under the terms of a provider agreement with a health insurance issuer that is in effect.

Uniform Claim—a standardized claim form as required under the Department of Insurance, Regulation 48.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2007 (September 2000).

§6007. Nonelectronic Claim Submission Standards

A. Contracted Medical Services

1. Any claim submitted by a contracted health care provider within 45 days of the date of service or discharge shall be paid to the claimant not more than 45 days from the date upon which a clean claim is received by a health insurance issuer or its legal agent, for an allowable expense on behalf of a covered person, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

2. Any claim submitted by a health care provider more than 45 days after the date of service or discharge or resubmitted because the original claim was incomplete or incorrect shall be paid to the claimant not more than 60 days from the date upon which a clean claim is received by a health insurance issuer or its legal agent, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

B. Non-Contracted Medical Services

1. Any claim for health insurance coverage benefits, whether submitted for payment by a covered person or by the health care provider rendering covered medical services that are not otherwise payable to the provider under a medical service contract with the health insurance issuer, shall be paid to the claimant not more than 30 days from the date upon which a clean claim is received by a health insurance issuer or its legal agent, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2007 (September 2000).

§6009. Electronic Claim Submission Standards

A. Any clean claim for a covered benefit payable to or on behalf of a covered person submitted by a contracted health care provider as an electronic claim shall be paid to the claimant not more than 25 days from the date upon which a clean claim form is received by the health insurance issuer or its legal agent, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6011. Thirty-Day Payment Standard

A. A health insurance issuer may elect to utilize a 30-day payment standard for compliance with the requirements of §§6007 and 6009 following provision of written notice to the Office of Health Insurance who shall provide notice of such changes. Health insurance issuers may cancel this election upon provision of written notice to the Office of Health Insurance. Any health insurance issuer electing to utilize a 30 day payment standard shall continue to meet all other requirements of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions: R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6013. Claim Handling Procedures

A. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of various claim submissions. Health insurance issuer claim handling procedures shall be filed with the Office of Health Insurance for review and approval. Such procedures shall include:

1. a process for documenting the date of actual receipt of claims. Health insurance issuers shall include appropriate safeguards to assure claims are appropriately classified and directed to the appropriate claims staff for review. The procedures shall include a process for documenting complaints regarding lost claims and appropriate corrective action protocols;

2. a process for reviewing claims for accuracy and acceptability. Health insurance issuers shall document their review process that includes procedures to verify compliance with uniform claim handling procedures. The procedures shall document the reasonable period of time taken to completely review each claim for completeness. The process and average timeframe utilized by the health insurance issuer shall be described in sufficient detail to document the average time required to determine if a uniform claim form has been correctly completed. For any claim that is found to be incomplete or otherwise not payable, the health insurance issuer shall provide specific written notice to the claimant within two days of all known reasons that the claim cannot be processed for payment within a reasonable period of time from the date of reviewing such claim for completeness. The procedures shall assure that the health insurance issuer prohibits the offsetting of claim payments for any other party, except as specifically provided by law, or with the expressed written consent of the claimant or by the contracted medical services provider contract. Except as required under R.S. 40:2010, a health insurance issuer whose policies or contracts of coverage do not allow benefit assignment shall be authorized to reject claims that are incorrectly completed as assigned claims;

3. a process for reporting all claims rejected by the health insurance issuer and the reason for such rejection.

B. Late Payment Procedures. 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 regulation receives a late payment adjustment equal to 1 percent of the amount due at the time the claim is paid. For any period greater than 25 days following the time frames specified in this regulation, the health insurance issuer shall pay to the claimant an additional late payment adjustment equal to 1 percent of the unpaid balance due for each month or partial month that such claim or any portion of the claim remains unpaid.

C. Compliant Procedures. The health insurance issuer's procedures shall include a process for insureds or enrollees to file complaints regarding provider demands for amounts owed by health insurance issuers. The procedures shall include all actions that will be taken by the health insurance issuer to address non-compliant providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions: R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6015. Limitations on Claim Filing and Audits

A. Health insurance issuers that limit the period of time that a claim may be filed for payment of benefits 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. For example, where a health insurance issuer limits the period for filing a claim for benefits to 12 months, then the health insurance issuer shall be limited to 12 months from the date of payment to perform any review or audit of the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6017. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2009 (September 2000).

Chapter 61. Regulation 16—Investment by Insurers of Part of Premium Paid, Return Guaranteed

§6101. Policy Directive Number Three to Insurance Companies

A. Effective January 1, 1959, no life insurance policy will be approved for use in the state of Louisiana, which does not guarantee to the policyholder or his or her beneficiary a return of all money, in excess of that part of the gross premium charged for life and disability insurance protection plus any guaranteed coupons, that is, any amount in excess of the net tabular premium, plus the loading for guaranteed coupons and expenses, which the policy provides shall be invested by the insurance company for the benefit of the policyholder, increased by the rate of interest stipulated in the contract.

B. Any policy which meets the above qualifications must also have printed on its first page, in prominent type, a brief description of all investment features.

C. Approval heretofore granted on all policies which do not comply with this directive, is hereby withdrawn, effective January 1, 1959, and all companies issuing such contracts are directed to cease issuing them within the state effective that date.

D. In order to assure compliance with this directive, all policies containing such investment features must be resubmitted together with all applicable sales promotion literature to be used therewith, to this office for new approval. Such policies will not be considered for approval in this state until the insurer submitting them furnishes evidence that such contracts have been approved in its domiciliary state.

E. This directive is not intended to apply to participating contracts of insurance whereby dividends are payable to a policyholder from divisible surplus of the company, nor to contracts. containing annual coupons the accrued maturity value of which are guaranteed payable to the policyholder upon lapse or withdrawal or to the beneficiary at death of the insured, unless these particular plans of insurance also contain investment features.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, October 1, 1958.

Chapter 62. Regulation 77—Medical Necessity Review Organizations

§6201. Purpose

A. The purpose of this regulation is to enforce the statutory requirements of Title 22 of the Louisiana Revised Statutes of 1950 that require health insurance issuers who seek to establish exception criteria or limitations on covered benefits that are otherwise offered and payable under a policy or certificate of coverage sold in this state, by requiring a medical necessity determination to be made by

the health insurance issuer. The statutory requirements also apply to any health benefit plan that establishes exception criteria or limitations on covered benefits that are otherwise offered and payable under a non-federal government benefit plan. Additionally, the statute establishes a process for Medical Necessity Review Organizations to qualify for state licensure and Independent Review Organizations to become certified by the Department of Insurance. The statutory requirements establish the intent of the legislature to assure licensed health insurance issuers and non-federal government benefit plans meet minimum quality standards and do not utilize any requirement that would act to impinge on the ability of insureds or government employees to receive appropriate medical advice and/or treatment from a health care professional. This regulation has no effect on the statutory requirements of R.S. 22:657. Emergency medical conditions as defined in R.S. 22:657 shall be covered and payable as provided therein.

B. This regulation implements the statutory requirements of R.S. §§22:2021, and Chapter 7 of Title 22 of the Louisiana Revised Statutes regarding the use of medical necessity to limit stated benefits in a fully insured health policy or HMO certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:844 (April 2002).

§6203. Definitions

Adverse Determination—a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care, or effectiveness.

Ambulatory Review—a review of health care services performed or provided in an outpatient setting.

Appropriate Medical Information—all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include, but are not necessarily limited to, one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity:

1. admission history and physical examination report;
2. physician's orders;
3. progress notes;
4. nursing notes;
5. operative reports;
6. anesthesia records;
7. hospital discharge summary;
8. laboratory and pathology reports;
9. radiology or other imaging reports;
10. consultation reports;
11. emergency room records; and
12. medication records.

Authorized Representative—a person to whom a covered person has given written consent to represent the covered person in an internal or external review of an adverse determination of medical necessity. *Authorized representative* may include the covered person's treating provider, if the covered person appoints the provider as his authorized representative and the provider agrees and waives in writing, any right to payment from the covered person other than any applicable copayment or coinsurance amount. In the event that the service is determined not to be medically necessary by the MNRO/IRO, and the covered person or his authorized representative thereafter requests the services, nothing shall prohibit the provider from charging the provider's usual and customary charges for all MNRO/IRO determined non-medically necessary services provided when such requests are in writing.

Case Management—a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

Certification or *Certify*—a determination by a reviewer regarding coverage of an admission, continued stay, or other health care service for the purpose of determining medical necessity, appropriateness of the setting, or level of care.

Clinical Peer—a physician or other health care professional who holds an unrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. Non-physician practitioners, including but not limited to nurses, speech and language therapists, occupational therapists, physical therapists, and clinical social workers, are not considered to be clinical peers and may not make adverse determinations of proposed actions of physicians (medical doctors shall be clinical peers of medical doctors, etc.).

Clinical Review Criteria—the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a reviewer to determine the necessity and appropriateness of covered health care services.

Commissioner—the Commissioner of Insurance.

Concurrent Review—a review of medical necessity, appropriateness of care, or level of care conducted during a patient's stay or course of treatment.

Covered Benefits or *Benefits*—those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person—a policyholder, subscriber, enrollee, or other individual covered under a policy of health insurance or HMO subscriber agreement.

Discharge Planning—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.

Disclose—to release, transfer, or otherwise divulge protected health information to any individual, entity, or person other than the individual who is the subject of the protected health information.

Emergency Medical Condition—a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the health of the individual in serious jeopardy;

2. with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy;

3. serious impairment to bodily function; or

4. serious dysfunction of any bodily organ or part.

Entity—an individual, person, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, agent, or contractor, or any combination of the foregoing.

External Review Organization—an independent review organization that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the Department of Insurance.

Facility—an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, inpatient hospice facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination—an adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process as set forth in this Chapter.

Health Benefit Plan—group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:250.1. Health benefit plan shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:250.1(3).

Health Care Professional—a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.

Health Care Provider or *Provider*—a health care professional, the attending, ordering, or treating physician, or a facility.

Health Care Services—services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Information—information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to any of the following:

1. the past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

2. the provision of health care services to a covered person; or

3. payment for the provision of health care services to a covered person.

Health Insurance Coverage—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.

Health Insurance Issuer—an insurance company, including a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

Medical Necessity Review Organization or *MNRO*—a health insurance issuer or other entity licensed or authorized pursuant to this Chapter to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

Prospective Review—a review conducted prior to an admission or a course of treatment.

Protected Health Information—health information that either identifies a covered person who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify a covered person.

Retrospective Review—a review of medical necessity conducted after services have been provided to a patient, but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Second Opinion—an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:845 (April 2002).

§6205. Authorization or Licensure as an MNRO

A. No health insurance issuer or health benefit plan, as defined in this Chapter, shall act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar medical determinations unless authorized to act as an MNRO by the commissioner as provided in this Chapter. Benefits covered under a health benefit plan sold or in effect in this state on or after January 1, 2001 shall be limited, excluded, or excepted from coverage under any medical necessity determination requirement, appropriateness of care determination, level of care needed, or any other similar determination only when such determination is made by an authorized or licensed MNRO as provided in this Chapter.

B. No entity acting on behalf of or as the agent of a health insurance issuer may act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations unless licensed as an MNRO by the commissioner as provided in this Chapter.

C. Any other entity may apply for and be issued a license under this Chapter to act as an MNRO for the purposes of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations on behalf of a health benefit plan.

D. Any entity licensed or authorized as an MNRO shall be exempt from the requirements of R.S. 40:2721 through 2736. The licensure, authorization, or certification of any entity as an MNRO or independent or external review organization shall be effective beginning on the date of first application for all entities who receive formal written authorization, licensure, or certification by the Commissioner of Insurance. This provision shall remain in effect until December 31, 2001. Any application filed after December 31, 2001 shall become effective upon final appproval by the Department of Insurance and not upon date of first application. Therefore any application submitted and filed after December 31, 2001, the licensure, authorization or certification of an entity as an MNRO or independent or external review organization shall be effective upon the date final approval is granted by the Commissioner of Insurance.

E. An integrated health care network or other entity contracting with a health insurance issuer for provision of covered services under a risk sharing arrangement, shall be allowed to make initial adverse medical necessity determinations provided the health insurance issuer remains responsible for provision of internal and external review requirements and has submitted the information required under Paragraph B.5 of §6207 for review and approval. In such instances, a covered person's request for an internal or external appeal of an adverse determination shall not require concurrence by a provider reimbursed under a risk sharing arrangement with the health insurance issuer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:846 (April 2002).

§6207. Procedure for Application to Act as an MNRO

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay an initial licensure fee as specified in §6211.D. The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include:

1. the name of the entity operating as an MNRO and any trade or business names used by that entity in connection with making medical necessity determinations;

2. the names and addresses of every officer and director of the entity operating as an MNRO, as well as the name and address of the corporate officer designated by the MNRO as the corporate representative to receive, review, and resolve all grievances addressed to the MNRO;

3. the name and address of every person owning, directly or indirectly, five percent or more of the entity operating as an MNRO;

4. the exact street and mailing address of the principal place of business where the MNRO will operate and conduct medical necessity review determinations;

5. a general description of the operation of the MNRO, which includes a statement that the MNRO does not engage in the practice of medicine or acts to impinge or encumber the independent medical judgment of treating physicians or health care providers;

6. a description of the MNRO's program that evidences it meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis. (Such program description shall evidence compliance with requirements of §6213 of this Chapter);

7. a sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making determinations of medical necessity;

8. for each individual that will be designated to make adverse medical necessity determinations pursuant to this Chapter:

a. a description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations; and

b. a written policy statement that the individual shall have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character;

c. a written policy statement that the individual will be required to attest that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as an MNRO under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include, but need not be limited, to the following:

1. the exact street and mailing address of the principal place of business where the MNRO will operate and conduct medical necessity review determinations;

2. a general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers;

3. a description of the MNRO's program that evidences it meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis. (Such program description shall evidence compliance with requirements of §6213 of this Chapter);

4. a sample copy of any contract, absent fees charged, with another health insurance issuer for making determinations of medical necessity;

5. for each individual that will be designated to make adverse medical necessity determinations pursuant to this Chapter:

a. a description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations;

b. a written policy statement that the individual shall have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

c. a written policy statement that the individual will be required to attest that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and, 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:847 (April 2002).

§6211. Expiration and Renewal of License for Entities other than Health Insurance Issuers

A. Licensure pursuant to this Chapter shall expire two years from the date approved by the commissioner unless the license is renewed for a two-year term as provided in this Section.

B. Before a license expires, it may be renewed for an additional two-year term if the applicant pays a renewal fee as provided in this Section and submits to the commissioner a renewal application on the form that the commissioner requires.

C. The renewal application required by the commissioner shall include, but need not be limited to, the information required for an initial application.

D. The fee for initial licensure and the fee for renewal of licensure shall each be $1,500.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014 and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6213. Scope and Content of Medical Necessity Determination Process

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for one or more health benefit plans. The program shall include the following:

1. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

2. data sources and clinical review of criteria used in decision-making. The appropriateness of clinical review criteria shall be fully documented;

3. the process for conducting appeals of adverse determinations including informal reconsiderations;

4. mechanisms to ensure consistent application of review criteria and compatible decisions;

5. data collection processes and analytical methods used in assessing utilization of health care services;

6. provisions for assuring confidentiality of clinical and proprietary information;

7. the organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan;

8. the medical director's responsibilities for day-to-day program management;

9. any quality management program utilized by the MNRO.

B. An MNRO shall file with the commissioner an annual summary report of its review program activities that includes a description of any substantive changes that have been implemented since the last annual report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6215. Medical Necessity Review Organization Operational Requirements

A. An MNRO shall use documented clinical review criteria that are based on sound clinical evidence. Such criteria shall be evaluated at least annually and updated if necessary to assure ongoing efficacy. An MNRO may develop its own clinical review criteria or it may purchase, license or contract for clinical review criteria from qualified vendors. An MNRO shall make available its clinical review criteria upon request to the commissioner who shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. An MNRO shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and oversee all adverse review decisions. Adverse determinations shall be made only by a duly licensed physician or clinical peer. An adverse determination made by an MNRO in the second level review shall become final only when a clinical peer has evaluated and concurred with such adverse determination.

C. An MNRO shall issue determination decisions in a timely manner pursuant to the requirements of this Chapter. At the time of the request for review, an MNRO shall notify the requestor of all documentation required to make a medical review determination. The requestor may include the covered person, an authorized representative, or a provider. In the event that the MNRO determines that additional information is required, it shall notify the requestor by telephone, within one workday of such determination, to request any additional appropriate medical information required. An MNRO shall obtain all information required to make a medical necessity determination, including pertinent clinical information, and shall have a process to ensure that qualified health care professionals performing medical necessity determinations apply clinical review criteria consistently.

D. At least annually, an MNRO shall routinely assess the effectiveness and efficiency of its medical necessity determination program and report any deficiencies or changes to the commissioner. Deficiencies shall include complaint investigations by the department or grievances filed with the MNRO that prompted the MNRO to change procedures or protocols.

E. An MNRO's data systems shall be sufficient to support review program activities and to generate management reports to enable the health insurance issuer or other contractor to monitor its activities.

F. Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight, which shall include, but not be limited to, the following:

1. a written description of the MNRO's activities and responsibilities, including reporting requirements;

2. evidence of formal approval of the medical necessity determination program by the health insurance issuer;

3. a process by which the health insurance issuer monitors or evaluates the performance of the MNRO.

G. Health insurance issuers who perform medical necessity determinations shall coordinate such program with other medical management activities conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

H. An MNRO shall provide health care providers with access to its review staff by a toll-free number that is operational for any period of time that an authorization, certification, or approval of coverage is required.

I. When conducting medical necessity determinations, the MNRO shall request only the information necessary to certify an admission to a facility, procedure or treatment, length of stay, frequency, level of care or duration of health care services.

J. Compensation to individuals participating in a medical necessity determination program shall not contain incentives, direct or indirect, for those individuals to make inappropriate or adverse review determinations. Compensation to any such individuals shall not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

K. An adverse determination shall not be based on the outcome of care or clinical information not available at the time the certification was made, regardless of whether the covered person or provider assumes potential liability for the cost of such care while awaiting a coverage determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6217. Procedures for Making Medical Necessity Determinations

A. An MNRO shall maintain written procedures for making determinations and for notifying covered persons and providers and other authorized representatives acting on behalf of covered persons of its decisions.

B.1. In no less than 80 percent of initial determinations, an MNRO shall make the determination within two working days of obtaining any appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. In no instance shall any determination of medical necessity be made later than 30 days from receipt of the request unless the patient's physician or other authorized representative has agreed to an extension.

2. In the case of a determination to certify a nonemergency admission, procedure, or service, the MNRO shall notify the provider rendering the service within one work day of making the initial certification and shall provide documented confirmation of such notification to the provider within two working days of making the initial certification.

3. In the case of an adverse determination of a nonemergency admission, the MNRO shall notify the provider rendering the service within one workday of making the adverse determination and shall provide documented confirmation of the notification to the provider within two working days of making the adverse determination.

C.1. For concurrent review determinations of medical necessity, an MNRO shall make such determinations within one working day of obtaining the results of appropriate medical information that may be required.

2. In the case of a determination to certify an extended stay or additional services, the MNRO shall notify the provider rendering the service within one working day of making the certification and shall provide documented confirmation to the provider within two working days of the authorization. Such documented notification shall include the number of intended days or next review date and the new total number of days or services approved.

3. In the case of an adverse determination, the MNRO shall notify the provider rendering the service within one working day of making the adverse determination and shall provide documented notification to the provider within one workday of such notification. The service shall be authorized and payable by the health insurance issuer without liability, subject to the provisions of the policy or subscriber agreement, until the provider has been notified in writing of the adverse determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider unless notified of such liability in advance.

D.1. For retrospective review determinations, the MNRO shall make the determination within 30 working days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 days from the date of service. The MNRO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud, misrepresentation, or nonpayment of premiums.

2. In the case of an adverse determination, the MNRO shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

E. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. An MNRO shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures.

F. An MNRO shall have written procedures listing the health or appropriate medical information required from a covered person or health care provider in order to make a medical necessity determination. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall also outline the process to be followed in the event that the MNRO determines the need for additional information not initially requested.

G. An MNRO shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, the MNRO may deny certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:849 (April 2002).

§6219. Informal Reconsideration

A. In a case involving an initial determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request, on behalf of the covered person, an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. Allowing a 10-day period following the date of the adverse determination for requesting an informal reconsideration shall be considered reasonable.

B. The informal reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one working day.

C. If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Informal reconsideration shall not be a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6221. Appeals of Adverse Determinations; Standard Appeals

A. An MNRO shall establish written procedures for a standard appeal of an adverse determination, which may also be known as a first level internal appeal. Such procedures shall be available to the covered person and to the provider acting on behalf of the covered person. Such procedures shall provide for an appropriate review panel for each appeal that includes health care professionals who have appropriate expertise. Allowing a 60-day period following the date of the adverse determination for requesting a standard appeal shall be considered reasonable.

B. For standard appeals, a duly licensed physician shall be required to concur with any adverse determination made by the review panel.

C. The MNRO shall notify in writing both the covered person and any provider given notice of the adverse determination, of the decision within thirty working days following the request for an appeal, unless the covered person or authorized representative and the MNRO mutually agree that a further extension of the time limit would be in the best interest of the covered person. The written decision shall contain the following:

1. the title and qualifying credentials of the physician affirming the adverse determination;

2. a statement of the reason for the covered person's request for an appeal;

3. an explanation of the reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position;

4. if applicable, a statement including the following:

a. a description of the process to obtain a second level review of a decision;

b. the written procedures governing a second level review, including any required time frame for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6223. Second Level Review

A. An MNRO shall establish a second level review process to give covered persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. An MNRO shall provide covered persons with adequate notice of this option, as described in §6221.C. Allowing a 30-day period following the date of the notice of an adverse standard appeal decision shall be considered reasonable.

B. An MNRO shall conduct a second level review for each appeal. Appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the MNRO and the health insurance issuer to the panel's decision.

C. An MNRO shall ensure that a majority of the persons reviewing a second level appeal are health care professionals who have appropriate expertise. An MNRO shall issue a copy of the written decision to a provider who submits an appeal on behalf of a covered person. In cases where there has been a denial of service, the reviewing health care professional shall not have a material financial incentive or interest in the outcome of the review.

D. The procedures for conducting a second level review shall include the following.

1. The review panel shall schedule and hold a review meeting within 45 working days of receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, an MNRO shall offer the covered person and any provider given a notice of adverse determination the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified of the time and place of the review meeting in writing at least 15 working days in advance of the review date; such notice shall also advise the covered person of his rights as specified in Paragraph 3 of this Subsection. The MNRO shall not unreasonably deny a request for postponement of a review meeting made by a covered person.

2. Upon the request of a covered person, an MNRO shall provide to the covered person all relevant information that is not confidential or privileged.

3. A covered person shall have the right to the following:

a. attend the second level review;

b. present his case to the review panel;

c. submit supporting material and provide testimony in person or in writing or affidavit both before and at the review meeting;

d. ask questions of any representative of the MNRO.

4. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

5. For second level appeals, a duly licensed and appropriate clinical peer shall be required to concur with any adverse determination made by the review panel.

6. The MNRO shall issue a written decision to the covered person within five working days of completing the review meeting. The decision shall include the following:

a. the title and qualifying credentials of the appropriate clinical peer affirming an adverse determination;

b. a statement of the nature of the appeal and all pertinent facts;

c. the rationale for the decision;

d. reference to evidence or documentation used in making that decision;

e. the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination;

f. notice of the covered person's right to an external review, including the following:

i. a description of the process to obtain an external review of a decision;

ii. the written procedures governing an external review, including any required time frame for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6225. Request for External Review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity. A covered person, with the concurrence of the treating health care provider, may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Chapter has been exhausted. A request for external review of an adverse determination may be made before the covered person has exhausted the MNRO's appeal, if any of the following circumstances apply.

1. The covered person has an emergency medical condition, as defined in this Chapter.

2. The MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both.

C. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B.1 of this Section, the covered person's treating health care provider may request an expedited external review. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B.2 of this Section, a standard external review shall be performed.

D. Nothing in this Section shall prevent an MNRO from establishing an appeal process, approved by the commissioner, that provides persons who are dissatisfied with the first level review decision an external review in lieu of requiring a second level review prior to requesting such external review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 22:3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:851 (April 2002).

§6227. Standard External Review

A. Within 60 days after the date of receipt of a notice of a second level appeal adverse determination, the covered person whose medical care was the subject of such determination may, with the concurrence of the treating health care provider, file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review, the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to its designated independent review organization. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a recommendation:

1. the covered person's pertinent medical records;

2. the treating health care professional's recommendation;

3. consulting reports from appropriate health care professionals and other documents submitted by the MNRO, covered person, or the covered person's treating provider;

4. any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations;

5. any applicable clinical review criteria developed exclusively and used by MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative and the covered person's health care provider within 30 days after the date of receipt of the second level determination information subject to an external review, unless a longer period is agreed to by all parties.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: La. R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:851 (April 2002).

§6229. Expedited Appeals

A. An MNRO shall establish written procedures for the expedited appeal of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to and may be initiated by the covered person, with the consent of the treating health care professional, or the provider acting on behalf of the covered person.

B. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or a similar specialty as would typically manage the case under review. The clinical peer or peers shall not have been involved in the initial adverse determination.

C. An MNRO shall provide an expedited appeal to any request concerning an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility. Such emergency services may include services delivered in the emergency room, during observation, or other setting that resulted in direct admission to a facility.

D. In an expedited appeal, all necessary information, including the MNRO's decision, shall be transmitted between the MNRO and the covered person, or his authorized representative, or the provider acting on behalf of the covered person by telephone, telefacsimile, or any other available expeditious method.

E. In an expedited appeal, an MNRO shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is commenced. If the expedited appeal is a concurrent review determination, the service shall be authorized and payable, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the determination in writing. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider until documented notification of such liability is provided to the covered person.

F. An MNRO shall provide written confirmation of its decision concerning an expedited appeal within two working days of providing notification of that decision if the initial notification was not in writing. The written decision shall contain the information specified in R.S. 22:3079.C(1) through (3).

G. An MNRO shall provide reasonable access, within a period of time not to exceed one workday, to a clinical peer who can perform the expedited appeal.

H. In any case where the expedited appeal process does not resolve a difference of opinion between the MNRO and the covered person or the provider acting on behalf of the covered person, such provider may request a second level appeal of the adverse determination.

I. An MNRO shall not provide an expedited appeal for retrospective adverse determinations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6231. Expedited External Review of Urgent Care Requests

A. At the time that a covered person receives an adverse determination involving an emergency medical condition of the covered person being treated in the emergency room, during hospital observation, or as a hospital inpatient, the covered person's health care provider may request an expedited external review. Approval of such requests shall not unreasonably be withheld.

B. For emergency medical conditions, the MNRO shall provide or transmit all necessary documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or any other available expeditious method.

C. In addition to the documents and information provided or transmitted, the independent review organization may consider the following in reaching a decision or making a recommendation:

1. the covered person's pertinent medical records;

2. the treating health care professional's recommendation;

3. consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider;

4. any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations;

5. any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate state licensing board of this state.

D. Within 72 hours after receiving appropriate medical information for an expedited external review, the independent review organization shall do the following:

1. make a decision to uphold or reverse the adverse determination;

2. notify the covered person, the MNRO, and the covered person's health care provider of the decision. Such notice shall include the principal reason or reasons for the decision and references to the evidence or documentation considered in making the decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6233. Binding Nature of External Review Decisions

A. Coverage for the services required under this Chapter shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under a health insurance policy or HMO subscriber agreement. Nothing in this Chapter shall be construed to require payment for services that are not otherwise covered pursuant to the evidence of coverage under the health insurance policy or HMO subscriber agreement or otherwise required under any applicable state or federal law.

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations. No entity shall hold itself out to the public as following the standards of a licensed or authorized MNRO that does not adhere to all requirements of this Chapter including the binding nature of external review decisions.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

D. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition. Causes of action for benefits or damages for actions involving or resulting from a decision made pursuant to this Chapter shall be limited to the party acting in bad faith, or involved in negligence, gross negligence or intentional misrepresentation of factual information about the covered person's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6235. Minimum Qualifications for Independent Review Organizations

A. The licensure, authorization, or certification of any entity as an MNRO or independent or external review organization shall be effective beginning on the date of first application for all entities who receive formal written authorization, licensure, or certification by the Commissioner of Insurance. This provision shall remain in effect until December 31, 2001. Any application filed after December 31, 2001 shall become effective upon final approval by the Department of Insurance and not upon date of first application. Therefore any application submitted and filed after December 31, 2001, the licensure, authorization or certification of an entity as an MNRO or independent or external review organization shall be effective upon the date final approval is granted by the Commissioner of Insurance. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

1. develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:

a. procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner;

b. procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;

c. procedures to ensure the confidentiality of medical and treatment records and clinical review criteria;

d. procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter;

2. establish a quality assurance program;

3. establish a toll-free telephone service to receive information related to external reviews on a 24-hour-day, 7-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

B. Any clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care provider who meets the following minimum qualifications:

1. be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. be knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:

a. the period of time spent actually treating patients with the same or similar medical condition of the covered person;

b. the period of time that has elapsed between the clinical experience and the present;

3. hold a nonrestricted license in a state of the United States and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review;

4. have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

C. In addition to the requirements of Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. In addition to the other requirements of this Section, in order to qualify to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor the clinical peer reviewer assigned by the independent organization to conduct the external review shall have a material professional, familial, or financial interest with any of the following:

1. the MNRO that is the subject of the external review;

2. any officer, director, or management employee of the MNRO that is the subject of the external review;

3. the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

4. the facility at which the recommended health care service or treatment would be provided;

5. the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review;

6. the covered person who is the subject of the external review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:853 (April 2002).

§6237. External Review Register

A. An MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, hereinafter referred to as the "register". For each request for external review, the register shall contain, at a minimum, the following information:

1. a general description of the reason for the request for external review;

2. the date received;

3. the date of each review;

4. the resolution;

5. the date of resolution;

6. except as otherwise required by state or federal law, the name of the covered person for whom the request for external review was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

C. The register compiled for a calendar year shall be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

D. The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

1. the total number of requests for external review;

2. the number of requests for external review resolved and their resolution;

3. a synopsis of actions being taken to correct problems identified.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6239. Emergency Services

A. Emergency services shall not be limited to health care services rendered in a hospital emergency room.

B. When conducting medical necessity determinations for emergency services, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency or if a provision of federal, state, or local law requires the use of a specific provider.

C. If a participating provider or other authorized representative of a health insurance issuer or health benefit plan authorizes emergency services, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item, treatment, or service furnished in reliance upon approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider of emergency services.

D. Coverage of emergency services shall be subject to state and federal laws as well as contract or policy provisions, including co-payments or coinsurance and deductibles.

E. For immediately required post-evaluation or post-stabilization services, an MNRO shall provide access to an authorized representative 24-hours a day, 7 days a week, to facilitate review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6241. Confidentiality Requirements

A. An MNRO shall annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6243. Severability

A. If any provision or item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation that can be given effect without the invalid provisions, item, or application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statute of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6245. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statute of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:855 (April 2002).

Chapter 63. Regulation 17—Reinstatement of Policies

§6301. Policy Directive Number Four to Non-Profit Funeral Associations

A. All insurance policies which were written before December 31, 1956 are subject to the following paragraph contained in R.S. 22:336:

> "A policyholder in good health and not over 70 years of age who has permitted his policy to lapse may rejoin upon terms fixed in the by-laws of the association and signing a statement in regard to his health as in the original application. Policyholders whose policies have lapsed and who are over 70 and under 90 years of age may reinstate only in the old age group."

B. Therefore, if a policyholder who was issued an assessment plan policy allows his policy to lapse, he may reinstate it upon the terms fixed in the by-laws of the association, or according to the provisions of his policy, but only if he or she is under 70 years of age when reinstatement is applied for. If a policyholder is over 70 years of age, he may be reinstated only in the old age group.

C. All policies issued on the industrial plan, after December 31, 1956, are subject to the provisions of R.S. 22:259(6), which reads as follows:

> "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."

D. Thus, if the policy in question is one issued after December 31, 1956, it may be reinstated upon the terms of the above Paragraph (6), or the terms of the insurance contract, if such contract contains more favorable language.

E. Any reinstatement of an insurance contract which is not accomplished according to the portions of the Insurance Code quoted above, is a violation of law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:336 and 22:259 (6).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, December 3, 1958.

Chapter 65. Regulation 18—Non-Profit Funeral Service Associations, Reinstatement of Lapsed Policies

§6501. Policy Directive Number Five to Non-Profit Funeral Service Associations

A. It has come to the attention of the Insurance Department that some non-profit funeral service associations are now reinstating policies which have been lapsed for many years. This is contrary to the insurance laws.

B. A survey of the non-profit association's charters and by-laws, if by-laws are on file with the Secretary of State, reveals that the most favorable reinstatement provisions allow reinstatement of lapsed policies within 90 days from date of lapse, provided all past due assessments are paid. In most cases the by-laws are silent with regard to reinstatement.

C. Lapsed policies may be reinstated only in accordance with the by-laws of the association. A policyholder whose policy has lapsed and who is over the age of 70 and under the age of 90 may reinstate only in the old age group. In the absence of the charter or by-laws pertaining to reinstatement, no lapsed policies may be reinstated.

D. All changes in the charter or by-laws of non-profit funeral service associations must be approved by the Commissioner of Insurance. No amendments to by-laws

concerning reinstatement of lapsed policies will be approved, which allows for reinstatement after 90 days from date of lapse.

E. All non-profit funeral service associations must cease reinstating lapsed policies which are issued on the assessment plan except in accordance with their present by-laws. This directive is effective May 1, 1960.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, April 28, 1960.

Chapter 67. Regulation 19—Inclusion of Burial Plots, Vaults, etc., as Part of Funeral Service-Change in Reserve Basis

§6701. Policy Directive Number Six to All Insurance Issuing Funeral Policies

A. The provisions of House Bill 322 will become effective on or about August 1, 1962. This bill amends Section 253 of the Insurance Code by adding Subsection A thereto:

> ALL POLICIES, ENDORSEMENTS OR RIDERS NOW IN YOUR POSSESSION WHICH INCLUDE PAYMENT OR FURNISHING OF BURIAL LOT, TOMBSTONE, MARKER, PLOT, TOMB, VAULT OR COPING ARE NOW DISAPPROVED. SUCH CONTRACTS MUST BE RESUBMITTED TO THE INSURANCE DEPARTMENT FOR APPROVAL IN ACCORDANCE WITH THIS DIRECTIVE.

B. For your information, the new Section 253 of the Insurance Code will read as follows:

> Section 253—Funeral Described: Cost Provision
>
> Every funeral policy shall state, in dollars, the value of the funeral and shall specify therein those things which shall constitute the funeral to be furnished, and shall provide for a stated cash payment which shall not be less than seventy-five per cent of the value of the funeral as stated in the policy in lieu of such funeral in the event it is impossible or impractical to furnish such services as set forth in the policy.
>
> A. Every funeral policy which includes among its benefits the payment for a burial lot, tombstone, marker, plot, tomb, vault or coping shall state in dollars the value of the said benefits and shall specify herein those things which shall constitute the said benefits to be furnished. Such policy shall be valued without the reduction of reserves provided for in R.S. 22:162. In the event such services are not furnished or paid for by the insurer then the amount of insurance shall be paid in cash to the beneficiary by the insurer, at the option of the beneficiary.

C. The effect of this legislation is to require that any funeral policy which includes any burial plot, tombstone, marker, plot, tomb, vault or coping must be reserved on a 100 percent basis, and if the official funeral director is not used, 100 percent of the benefits promised by the insurance contract must be paid in cash to the beneficiary.

D. Therefore, all policies, endorsements or riders now in your possession which include the above enumerated benefits, and which may have been heretofore approved, are now disapproved. No funeral policy which includes any of the above benefits shall be issued until such policy has been submitted to and approved by the Insurance Department.

E. No endorsement, rider or attachment of any kind which includes any of the above described benefits shall be used in this state until after it and the policy to which it will be attached have been submitted together to and approved by the Insurance Department.

F. Any company wishing to issue such policies may write or come to the Insurance Department concerning any provision of such policy which may be in doubt.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 9, 1962.

Chapter 69. Regulation 21—Special Policies and Provisions: Prohibitions, Regulations, and Disclosure Requirements

§6901. Policy Directive Number Seven to All Companies Authorized to Write Life Insurance in the State of Louisiana

A. Authority and Purpose

1. This directive is issued under the authority granted to the Insurance Commissioner by the *Louisiana Insurance Code* for the purpose of protecting the Louisiana insurance-buying public and the insurers from the effect of sales of certain types of insurance policies which experience has shown, in this and other states, has not been in the public interest.

2. Effective November 12, 1962, no policy of the type described in §6901.A.3 shall be approved for use in the state of Louisiana. Any such policy of the type described in §6901.A.3 which has heretofore been approved for use in Louisiana shall not be used after March 1, 1963, the approval of such form being specifically revoked on such date.

3.a. A policy form which guarantees a certain amount each year, either level or variable, where such amount is predicated upon a specified number of shares of stock of the company. Such forms usually provide that a certain amount is payable to the owner of the policy, usually upon payment of the second annual premium, or it will provide that the owner of the policy receive the same amount of money as the dividend which is declared upon a given number of shares of stock of the company during the year.

b. A policy which usually has some identifying language indicating that it will be made available to a limited number of persons or sold in specifically pre-determined numbers of units of fixed dollar amounts. Also, any policy form which contains provisions representing that the policyholder will be eligible to participate, with special advantage not available to persons holding other types of participating or nonparticipating policies issued by the same company, in any future distribution of general company profits. Such forms are often so drafted that it appears to a prospective policyholder that he is purchasing a preferential

share of future profits and earnings of the company, rather than purchasing life insurance policies which may be subject to refunds of premiums.

i. Every participating contract shall stipulate that dividends, if any, shall be ascertained and apportioned by the Board of Directors, and shall not specify the sources of such dividends.

c. Any policy for which an extra premium is paid which is not used to purchase insurance but where such extra premium is set aside in a fund which is to be invested by the insurer for the benefit of the policyholders holding this type of contract. Dividends or guaranteed allocations or coupons used in connection with the policy are used to purchase stock in business corporations or other insurance companies for the exclusive benefit of the purchasers of the policies. Such policies contain language wherein it is indicated that dividends and capital gains from stock purchased with the excess portion of the premium paid for the policy are to be accumulated and distributed exclusively to those policyholders who continue to be such to the end of a specified period of time. Those persons who, for one reason or another, terminate or lapse their policies, or if the face amount of the policy is paid by reason of death of the insured, do not participate in the final distribution of the funds, although they may have contributed substantially to its formation.

4. Policies of the type described in §6901.A.3 generally purport to provide a means to an end result that is not authorized by statute, and in many cases, an end result that is without reasonable expectation of achievement. Such policies usually represent as an inducement to the purchase of insurance that the person who buys such a policy is procuring a preferential interest in the future profits and earnings of the insurance company. Inasmuch as distribution of earnings, profits or surplus must be fair and equitable to all policyholders, and must not discriminate unfairly between individuals of the same class and equal expectation of life, policies containing such provisions will henceforth be considered as contrary to statute and the public interest.

a. It is also in the public interest that every policy of life insurance should bear in a prominent place a reasonably accurate brief description of the nature of the insurance contract afforded by the insurance policy. To that end, phrases as "profit sharing", "charter plan", "Founder's Plan" and other such words and phrases when used in connection with any type of life insurance policy shall be deemed to be misleading and ambiguous and a violation of the insurance statutes of this state.

5. Insurance policies which include a series of coupons or additional benefits featured in combination with an insurance contract will be permitted in this state. Such coupons are usually pure endowments, and are essentially a return of a portion of the premium which the policyholder has already paid. This being true, they should be properly identified as such. Therefore, the policy shall state that a portion of the premium charged is for the coupon benefit. Such language shall be prominently displayed in proximity to the language used to set forth the consideration for the policy.

a. For policies issued under R.S. 22:163, the reserves and nonforfeiture values of such policies must be so calculated that the present value of the pure endowments represented by the coupons, on the same mortality table and interest rate as the policy, are included in the calculation of the nonforfeiture factors, the first year and net renewal premiums and the reserves and non-forfeiture values, but shall be excluded in the calculation of the equivalent level amount.

b. For policies issued under R.S. 22:162(C), the calculations under ordinary insurance shall conform to Illinois Standard Valuation or shall produce reserves equivalent to such standard. The Illinois Standard referred to reads as follows:

> "If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than twenty years from the date of the policy or under an endowment preliminary term policy, exceeds that charged for like insurance under twenty-payment life preliminary term policies of the same company, the reserve thereon at the end of any year, including first, shall not be less than the reserve on a twenty-payment life preliminary term policy issued in the same year and at the same age together with an amount which shall be equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment at the end of the premium payment period equal to the difference between the value at the end of such period of such twenty-payment life preliminary term policy and the full reserve at such time of such a limited payment life or endowment policy. The premium-payment period is the period during which premiums am concurrently payable under such twenty-payment life preliminary term policy and such limited-payment life or endowment policy."

c. The premiums referred to shall be construed to mean net premiums so as to make the law's application uniform for all companies. The new 20-payment life premium, on the full one-year preliminary term basis, is thus made the measure for determining whether the premium for, and the valuation of, other plans of insurance shall be upon the full preliminary term basis or the 20-payment life preliminary term basis. Therefore, the basis is determined not so much by plan of insurance as by relative size of premium at the age of issue.

d. In order that the Insurance Department may be sure that this directive is complied with, each such form which is filed must include a complete and detailed description of the actuarial basis of the policy together with formulae and calculations for at least one specimen age. Also the cover letter must certify that the recommendations of the Hooker Committee have been complied with for policies issued under R.S. 22:163.

6. Before consideration will be given to any policy, the letter of transmittal must contain a certification by an executive officer that such policy has been approved by the insurer's domiciliary state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22.162(C) and 22:163.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, October 1, 1962.

Chapter 71. Regulation 24—Proxies, Consents and Authorizations of Domestic Stock Insurers

§7101. Application of Regulation

A. This regulation is applicable to each domestic stock insurer which has any class of equity security held of record by one hundred or more persons; provided, however, that this regulation shall not apply to any insurer if 95 percent or more of its equity securities are owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than five hundred persons. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and the applicable regulations promulgated thereunder, shall be exempt from the provisions of this regulation with respect to any class of securities subject to SEC jurisdiction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7103. Proxies, Consents and Authorizations

A. No domestic stock insurer, or any director, officer or employee of such insurer subject to §7101, or any other person, shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent or authorization in respect of any class of equity security of such insurer held of record by one hundred or more persons in contravention of this regulation and §§7123 and 7125, Schedules A and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7105. Disclosure of Equivalent Information

A. Unless proxies, consents or authorizations in respect of any class of equity security of a domestic insurer subject to §7101 hereof are solicited by or on behalf of the management of such insurer from the holders of record of such security in accordance with this regulation and the Schedules hereunder prior to any annual or other meeting of such security holders, such insurer shall, in accordance with this regulation and such further regulations as the commissioner may adopt, file with the commissioner and transmit to all security holders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made. Such insurer shall transmit a written information statement containing the information specified in §7109.D to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited on behalf of the management of the insurer; provided, that in the case of a class of securities in unregistered or bearer form such statement need be transmitted only to those security holders whose names and addresses are known to the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7107. Definitions

A. The definitions and instructions set out in Schedule SIS, as promulgated by the National Association of Insurance Commissioners, shall be applicable for purposes of this regulation.

Solicit and *Solicitation*—for purposes of this regulation shall include:

a. any request for a proxy, whether or not accompanied by or included in a form of proxy; or

b. any request to execute or not to execute, or to revote, a proxy;

c. the furnishing of a proxy or other communication to security holders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

Solicit and *Solicitation*—shall not include:

a. any solicitation by a person in respect of equity security of which he is the beneficial owner;

b. action by a broker or other person in respect to equity security carried in his name or in the name of his nominee in forwarding to the beneficial owner of such equity security soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

c. the furnishing of a form of proxy to a security holder upon the unsolicited request of such security holder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965.

§7109. Information to Be Furnished to Security Holders

A. No solicitation subject to this regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in §7123.

B. If the solicitation is made on behalf of the management of the insurer and relates to in annual meeting of security holders at which directors are to be elected, each proxy statement furnished pursuant to §7109.A shall be accompanied or preceded by an annual report (in preliminary or final form) to such security holders containing such financial statements for the last fiscal year

as are referred to in Schedule SIS under the heading "Financial Reporting to Security Holders". Subject to the foregoing requirements with respect to financial statements, the annual report to security holders may be in any form deemed suitable by the management.

C. Two copies of each report sent to the security holders pursuant to §7109 shall be mailed to the commissioner not later than the date on which such report is first sent or given to security holders or the date on which preliminary copies of solicitation material are filed with the commissioner pursuant to §7113.A, whichever date is later.

D. If no solicitation is being made by management of the insurer with respect to any annual or other meeting, such insurer shall mail to every security holder of record at least twenty days prior to the meeting date, an information statement as required by §7109.C, containing the information called for by §7123, other than §7123.A, C, and D, which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting. If such information statement relates to an annual meeting at which directors are to be elected, it shall be accompanied by an annual report to such security holders in the form provided in §7109.B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7111. Requirements as to Proxy

A. The form of proxy shall:

1. indicate in bold-face type whether or not the proxy is solicited on behalf of the management;

2. provide a specifically designated blank space for dating the proxy; and

3. identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or security holders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to §7111.C.

B.1. Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in bold-face type how it is intended to vote the shares or authorization represented by the proxy in each such case.

2. A form of proxy which provides both for elections to office and for action on other specified matters shall be prepared so as to clearly provide, by a box or otherwise, means by which the security holder may withhold authority to vote for elections to office. Any such form of proxy which is executed by the security holder in such manner as not to withhold authority to vote for elections to office shall be deemed to grant such authority, provided the form of proxy so states in bold-face type.

C. A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further "that a specific statement to that effect is made in the proxy statement or in the form of proxy. (A proxy may also confer discretionary authority with respect to any proposal omitted from the proxy statement and form of proxy pursuant to §7115.)*

D. No proxy shall confer authority:

1. to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement; or

2. to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to security holders.

E. The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to §7111.B a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

F. The information included in the proxy statement or information statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements or information statements shall be clearly and legibly presented.

*To be used only if Section Eight is adopted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7113. Material Required to be Filed

A. Two preliminary copies of the information statement or the proxy statement and form of proxy and any other soliciting material to be furnished to security holders concurrently therewith shall be filed with the commissioner at least 10 days prior to the date definitive copies of such material are first sent or given to security holders, or such shorter period prior to that date as the commissioner may authorize upon a showing of good cause therefor.

B. Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to security holders subsequent to the proxy statements shall be filed with the commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to security holders or a shorter period prior to such date as the commissioner may authorize upon a showing of good cause therefor.

C. Two definitive copies of the information statement or the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to security holders, shall be filed with, or mailed for filing to, the commissioner not later than the date such material is first sent or given to the security holder.

D. Where any information statement or proxy statement, form of proxy or other material filed pursuant to these rules is amended or revised, two of the copies shall be marked to clearly show such changes.

E. Copies of replies to inquiries from security holders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to §7113.

F. Notwithstanding the provisions of §7113.A and B and of §7121.E, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the commissioner as required by §7113.C not later than the date such material is used or published. The provisions of §7113.A and B and §7121.E shall apply, however, to any reprints or reproductions of all or any part of such material.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7115. Proposals of Stockholders

(This Section would provide a procedure for presentation of security holder proposals where the insurance supervisory official deems the state's corporate or other laws do not provide satisfactory methods for such presentation. It was agreed that a decision on its inclusion in the regulations be postponed until this June, 1965 meeting and that, in the meantime, the subject be given further study.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7117. False or Misleading Statements

A. No proxy statement, form of proxy, notice of meeting, information statement, or other communication, written or oral, subject to this regulation, shall contain any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7119. Prohibition of Certain Solicitations

A. No person making a solicitation which is subject to this regulation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the security holder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965.

§7121. Special Provisions Applicable to Election Contest

A. Applicability. This Section shall apply to any solicitation subject to this regulation by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of security holders.

B. Participant or Participant in a Solicitation

1. For purposes of this Section the terms *participant* and *participant in a solicitation* include:

a. the insurer;

b. any director of the insurer, and any nominee for whose election as a director proxies are solicited;

c. any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

2. For the purposes of §7121 the terms *participant* and *participant in a solicitation* do not include:

a. a bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of equity security and who is not otherwise a participant;

b. any person or organization retained or employed by a participant to solicit security holders or any person who merely transmits proxy soliciting materials or performs ministerial or clerical duties;

c. any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;

d. any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or

e. any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

C. Filing of Information Required by §7125, Schedule B

1. No solicitation subject to §7121 shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the commissioner may authorize upon a showing of good cause therefor, there has been filed, with the commissioner by or on behalf of each participant in such solicitation, a statement, in duplicate, containing the information specified by §7125, Schedule B, and a copy of any material proposed to be distributed to security holders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to security holders should be deferred until the commissioner's comments have been received and complied with.

2. Within five business days after a solicitation subject to §7121 is made by the management of an insurer, or such longer period as the commissioner may authorize upon a showing of good cause therefor, there shall be filed with the commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement, in duplicate, containing the information specified by §7125, Schedule B.

3. If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to §7121 in opposition thereto, a statement, in duplicate, containing the information specified in §7125, Schedule B shall be filed with the commissioner by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

4. If, subsequent to the filing of the statements required by §7121.C.1, 2, and 3, additional persons become participants in a solicitation subject to this rule, there shall be filed with the commissioner by or on behalf of each such person, a statement, in duplicate, containing the information specified by §7125, Schedule B, within three business days after such person becomes a participant, or such longer period as the department may authorize upon a showing of good cause therefor.

5. If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the commissioner.

6. Each statement and amendment thereto filed pursuant to §7121.C.6 shall be part of the public files of the commissioner.

D. Solicitations Prior to Furnishing Required Written Proxy Statement

1. Notwithstanding the provisions of §7109.A, a solicitation subject to §7121 may be made prior to furnishing security holders a written proxy statement containing the information specified in §7123, Schedule A with respect to such solicitation, provided that:

a. the statements required by §7121.C are filed by or on behalf of each participant in such solicitation;

b. no form of proxy is furnished to security holders prior to the time the written proxy statement required by §7109.A is furnished to such persons; provided, however, that §7121.D.1.b shall not apply where a proxy statement then meeting the requirements of §7123, Schedule A has been furnished to security holders;

c. at least the information specified in §7121.C.2 and 3 of the statements required by §7121.C to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to security holders in connection with the solicitation;

d. a written proxy statement containing the information specified in §7123, Schedule A with respect to a solicitation is sent or given security holders at the earliest practicable date.

E. Solicitations Prior to Furnishing Required Written Proxy Statement—Filing Requirements

1. Two copies of any soliciting material proposed to be sent or given to security holders prior to the furnishing of the written proxy statement required by §7109.A shall be filed with the commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the commissioner may authorize upon a showing of good cause therefor.

F. Application of §7121 to Report

1. Notwithstanding the provisions of §7109.B and C, two copies of any portion of the report referred to in §7109.B which comments upon or refers to any solicitation subject to §7121, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the commissioner as proxy material subject to this regulation. Such portion of the report shall be filed with the commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to security holders.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965.

§7123. Schedule A—Information Required in Proxy Statement

A. Revocability of Proxy

1. State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

B. Dissenters' Right of Appraisal

1. Outline briefly the rights of appraisal or similar rights of dissenting security holders with respect to any matter to be acted upon and indicate any statutory procedure

required to be followed by such security holders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

C. Persons Making Solicitations Not Subject to §7121

1. If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management, in writing, that he intends to oppose any action intended to be taken by the management and indicate the action which he intends to oppose.

2. If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

3. If the solicitation is to be made by specially engaged employees or paid solicitors, state:

a. the material features of any contract or arrangement for such solicitation and identify the parties; and

b. the cost or anticipated cost thereof.

D. Interest of Certain Persons in Matters to Be Acted Upon

1. Describe briefly any substantial interest, direct or indirect, by security holders or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

E. Voting Securities

1. State, as to each class of voting equity security of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

2. Give the date as of which the record list of security holders entitled to vote at the meeting will be determined. If the right to vote is not limited to security holders of record on that date, indicate the conditions under which other security holders may be entitled to vote.

3. If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

F. Nominees and Directors

1. If action is to be taken with respect to the election of directors, furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting.

a. Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him, and indicate which persons are nominees for election as directors at the meeting.

b. State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of security holders at a meeting for which proxies were solicited under this regulation.

c. If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

d. State, as of the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such equity securities make a statement to that effect.

G. Remuneration and Other Transactions with Management and Others

1. Furnish the information reported or required in item one of Schedule SIS under the heading "Information Regarding Management and Directors" if action is to be taken with respect to:

a. the election of directors;

b. any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate;

c. any pension or retirement plan in which any such person will participate; or

d. the granting of extension to any such person of any options, warrants or rights to purchase any equity securities, other than warrants or rights issued to security holders, as such, on a pro rata basis. If the solicitation is made on behalf of persons other than the management, information shall be furnished only as to Item IA of the aforesaid heading of Schedule SIS.

H. Bonus, Profit Sharing and Other Remuneration Plans

1. If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan, of the insurer furnish the following information:

a. a brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation;

b. the amounts which would have been distributable under the plan during the last calendar year to:

i. each person named in item §7123.G;

ii. directors and officers as a group; and

iii. to all other employees as a group, if the plan had been in effect;

c. if the plan to be acted upon may be amended (other than by a vote of security holders) in a manner which would materially increase the cost thereof to the insurer or materially alter the allocation of the benefits as between the groups specified in §7123.H.1.b, the nature of such amendments should be specified.

I. Pension and Retirement Plans

1. If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

a. a brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation;

b. state:

i. the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period;

ii. the estimated annual payment to be made with respect to current services; and

iii. the amount of such annual payments to be made for the benefit of:

(a). each person named in §7123.G;

(b). directors and officers as a group; and

(c). employees as a group;

c. if the plan to be acted upon may be amended (other than by a vote of security holders) in a manner which would materially increase the cost thereof to the insurer or materially alter the allocation of the benefits as between the groups specified in §7123.I.b.iii the nature of such amendments should be specified.

J. Options, Warrants, or Rights

1. If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all security holders on a pro rata basis, furnish the following information:

a. the title and amount of equity security called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the equity security called for or to be called for by the warrants, as of the latest practicable date;

b. if known, state separately the amount of equity security called for or to be called for by warrants received or to be received by the following persons, naming each such person:

i. each person named in §7123.G; and

ii. each other person who will be entitled to acquire 5 percent or more of the equity security called for or to be called for by such warrants;

c. if known, state also the total amount of equity security called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

K. Authorization or Issuance of Stock

1. If action is to be taken with respect to the authorization or issuance of any equity security of the insurer furnish the title, amount and description of the equity security to be authorized or issued.

2. If the shares of equity security are other than additional shares or common equity security of a class outstanding, furnish a brief summary of the following, if applicable:

a. dividend;

b. voting;

c. liquidation;

d. preemptive and conversion rights;

e. redemption and sinking fund provisions;

f. interest rate and date of maturity.

3. If the shares of equity security to be authorized or issued are other than additional shares of common equity security of a class outstanding, the commissioner may require financial statements comparable to those contained in the annual report.

L. Mergers, Consolidations, Acquisitions and Similar Matters

1. If action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

a. the rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting security holders in order to perfect such rights;

b. the material features of the plan or agreement;

c. the business done by the company to be acquired or whose assets are being acquired;

d. if available, the high and low sales prices for each quarterly period within two years;

e. the percentage of outstanding shares which must approve the transaction before it is consummated.

2. For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

a. a comparative balance sheet as of the close of the last two fiscal years;

b. a comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earnings per share after related taxes and cash dividends paid per share;

c. a pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

M. Restatement of Accounts

1. If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information.

a. State the nature of the restatement and the date as of which is to be effective.

b. Outline briefly the reasons for the restatement and for the selection of the particular effective date.

c. State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

N. Matters Not Required to Be Submitted

1. If action is to be taken with respect to any matter which is not required to be submitted to a vote of security holders, state the nature of such matter, the reason for submitting it to a vote of security holders and what action is intended to be taken by the management in the event of a negative vote on the matter by the security holders.

O. Amendment of Charter, By-Laws, or Other Documents

1. If action is to be taken with respect to any amendment of the insurer's charter, by-laws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

§7125. Schedule B—Information to Be Included in Statements Filed by or on Behalf of a Participant (other than the insurer) in a Proxy Solicitation in an Election Contest

A. Insurer. State the name and address of the insurer.

B. Identity and Background

1. State the following:

a. your name and business address;

b. your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

2. State the following:

a. your residence address;

b. information as to all material occupations, positions, offices or employments during the last 10 years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

3. State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past 10 years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

4. State whether or not, during the past 10 years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item need not be included in the proxy statement or other proxy soliciting material.

C. Interest in Equity Security of the Insurer

1. State the amount of each class of equity security of the insurer which you own beneficially, directly or indirectly.

2. State the amount of each class of equity security of the insurer which you own of record but not beneficially.

3. State with respect to the equity security specified in §7125.C.1 and 2, the amounts acquired within the past two years, the dates of acquisition and the amounts acquired on each date.

4. If any part of the purchase price or market value of any of the equity security specified in §7125.C.3 is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such equity security, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

5. State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any equity security of the insurer including, but not limited to, joint ventures, loan or option arrangements, puts or calls, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so name the persons with whom such contracts, arrangements, or understanding exist and give the details thereof.

6. State the amount of equity security of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.

7. State the amount of each class of equity security of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

D. Further Matters

1. Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

2. Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

3.a. State whether or not you or any of your associates have any arrangement or understanding with any person:

i. with respect to any future employment by the insurer or its subsidiaries or affiliates; or

ii. with respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

b. If so, describe such arrangement or understanding and state the names of the parties thereto.

E. Signature

1. The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

_____ _____

(Date) (Signature of Participant or Authorized Representative)

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1525 and 22:1533.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 17, 1965, amended April 1, 1967.

Chapter 73. Regulation 25—Sale of Stock to Public; Stock Options

§7301. Sale of Stock; Stock Options

A. No new old line legal reserve life insurance company will be registered to sell stock to the public unless at least $1,000,000 is sold.

B. No new industrial life insurance company will be registered to sell stock to the public unless at least $300,000 is sold.

C. At least 100 percent of the proceeds of the sale of stock must be placed in escrow until either of the above amounts has been sold or until the expiration of one year from the date of original registration.

D. No company will be registered with a par value of less than $1 per share.

E. Stock options must comply with "Restricted Stock Options" under the *Internal Revenue Code*, and such options can not exceed 10 percent of the total outstanding shares after the sale to the public.

F. All officers, directors, incorporators or promoters of insurance companies must pay at least 85 percent of the public offering price into the company. No stock may be subscribed for at par by such individuals and then a public offering made at a price considerably in excess of par.

G. No stock of an insurance company, whether original or secondary, can be sold to pay off a personal loan of the holder thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, May 28, 1964.

Chapter 75. Regulation 27—Insider Trading of Equity Securities of a Domestic Stock Insurance Company

Subchapter A. General Application

§7501. Definitions

Act—Act 8 of the 1966 Legislature of Louisiana.

Class—all securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges.

Equity Security—any stock or similar security; or any voting trust certificate or certificate of deposit for such a 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.

Insurer—any domestic stock insurance company, with an equity security subject to the provisions of Act 8 of the 1966 Legislature of Louisiana and not exempt thereunder.

Officer—a president, vice president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

Securities Held of Record—

1. for the purpose of determining whether the equity securities of an insurer are held of record by 100 or more persons, securities shall be deemed to be *held of record* by each person who is identified as the owner of such securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

a. in any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as such an owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record;

b. securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person;

c. securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person;

d. securities held by two or more persons as co-owners shall be included as held by one person;

e. each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if such securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of persons;

f. securities registered in substantially similar names where the insurer has reason to believe because of the address or other indications that such names represent the same person, may be included as held of record by one person;

2. notwithstanding Paragraph 1 of this definition:

a. securities held, to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit receipts or similar evidences of interest in such securities; provided, however, that the insurer may rely in good faith on such information as is received in response to its request from a nonaffiliated insurer of the certificates or evidences of interest;

b. if the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the Act, the beneficial owners of such securities shall be deemed to be the record owners thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7503. Transactions Exempted from the Operation of Section 1526 of the Act

A. Any acquisition or disposition of any equity security by a director or officer of an insurer within six months prior to the date on which the Act shall first become applicable with respect to the equity securities of such insurer shall not be subject to the operation of Section 1526 of the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

Subchapter B. Regulations under Section 1525 of the Act

§7509. Filing of Statements

A. Initial statements of beneficial ownership of equity securities required by Section 1525 of the Act shall be filed on Form A, §7561. Statements of changes in such beneficial ownership required by Section 1525 shall be filed on Form B, §7563. All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7511. Ownership of More than 10 Percent of an Equity Security

A. In determining, for the purpose of Section 1525 of the Act whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, such class shall be deemed to consist of the total amount of such class outstanding, exclusive of any securities of such class held by or for the account of the insurer or a subsidiary of the insurer; except that for the purpose of determining percentage ownership of voting trust certificates or certificates of deposit for equity securities, the class of voting trust certificates or certificates of deposit shall be deemed to consist of the amount of voting trust certificates or certificates of deposit issuable with respect to the total amount of outstanding equity securities of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not all of such outstanding securities have been so deposited. For the purpose of §7511 a person acting in good faith may rely on the information contained in the latest Convention Form Statement filed with the commissioner with respect to the amount of securities of a class outstanding or in the case of voting trust certificates or certificates of deposit the amount thereof issuable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7513. Disclaimer of Beneficial Ownership

A. Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that such person is, for the purpose of the Act, the beneficial owner of any equity securities covered by the statement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7515. Exemptions from Sections 1525 and 1526 of the Act

A. During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from Sections 1525 and 1526 of the Act:

1. executors or administrators of the estate of a decedent;

2. guardians or committees for an incompetent; and

3. receivers, trustees in bankruptcy, assignees for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

B. After the 12-month period following their appointment or qualification the foregoing persons shall be required to file reports with respect to the securities held by the estates which they administer under Section 1525 of the Act and shall be liable for profits realized from trading in such securities pursuant to Section 1526 of the Act only when the estate being administered is a beneficial owner of more than 10 percent of any class of equity security of an insurer subject to the Act.

C. Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt from Sections 1525 and 1526 during the time they are held by the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7517. Exemption from the Act of Securities Purchased or Sold by Odd-Lot Dealers

A. Securities purchased or sold by an odd-lot dealer:

1. in odd lots so far as reasonably necessary to carry on odd-lot transactions; or

2. in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from the provisions of the Act with respect to participation by such odd-lot dealer in such transactions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7519. Certain Transactions Subject to Section 1525 of the Act

A. The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed such a change in the beneficial ownership of the security to which such privilege relates as to require the filing of a statement reflecting the acquisition or disposition of such privilege. Nothing in §7519, however, shall exempt any person from filing the statements required upon the exercise of such option, put, call, spread or straddle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7521. Ownership of Securities Held in Trust

A. Beneficial ownership of a security for the purpose of Section 1525 shall include:

1. the ownership of securities as a trustee where either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust;

2. the ownership of a vested beneficial interest in a trust; and

3. the ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

B. Except as provided in §7521.C, beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of Section 1525 where less than 20 percent in market value of the securities having a readily ascertainable market value held by such trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from Section 1525 with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of such securities by the trust is made without prior approval by the settlor or beneficiary. No exemption pursuant to §7521 shall, however, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of Section 1525.

C. In the event that 10 per cent of any class of any equity security of an insurer is held in a trust, that trust and the trustees thereof as such shall be deemed a person required to file the reports specified in Section 1525 of the Act.

D. Not more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or 10 percent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or 10 percent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file any such report so long as he relies in good faith upon an understanding that the trustee of such trust will file whatever reports might otherwise be required of such beneficiary.

E.1. As used in §7521 the *immediate family* of a trustee means:

a. a son or daughter of the trustee, or a descendant of either;

b. a stepson or stepdaughter of the trustee;

c. the father or mother of the trustee, or an ancestor of either;

d. a stepfather or stepmother of the trustee;

e. a spouse of the trustee.

2. For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of such person by blood.

F. In determining, for the purposes of Section 1525 of the Act, whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, the interest of such person in the remainder of a trust shall be excluded from the computation.

G. No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under Section 1525, with respect to his indirect interest in portfolio securities held by:

1. a pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan;

2. a business trust with over 25 beneficiaries.

H. Nothing in §7521 shall be deemed to impose any duties or liabilities with respect to reporting any transaction of holding prior to its effective date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7523. Exemption for Small Transactions

A. Any acquisition of securities shall be exempt from Section 1525 where:

1. the person effecting the acquisition does not within six months thereafter effect any disposition, otherwise than by way of gift, of securities of the same class; and

2. the person effecting such acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six months' period during which the acquisition occurs.

B. Any acquisition or disposition of securities by way of gift, where the total amount of such gifts does not exceed $3,000 in market value for any six months' period, shall be exempt from Section 1525 and may be excluded from the computations prescribed in §7523.A.2.

C. Any person exempted by §7523.A or B shall include in the first report filed by him after a transaction within the exemption a statement showing his acquisitions and dispositions for each six months' period or portion thereof which has elapsed since his last filing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7525. Exemption from Section 1526 of the Act of Transactions which Need Not Be Reported under Section 1525

A. Any transaction which has been or shall be exempted from the requirements of Section 1525 of the Act shall, insofar as it is otherwise subject to the provisions of Section 1526, be likewise exempted from Section 1526.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

Subchapter C. Regulations under Section 1526 of the Act

§7531. Exemption from Section 1526 of Certain Transactions Effected in Connection with a Distribution

A. Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of Section 1526 of the Act, to the extent specified in §7531 as not comprehended within the purpose of said Section of the Act, upon the following conditions:

1. the person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of such business, in the distribution of such block of securities;

2. the security involved in the transaction is:

a. a part of such block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of such block of securities; or

b. a security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over-allotment or other short position created in connection with such distribution; and

3. other persons not within the purview of Section 1526 of the Act are participating in the distribution of such block of securities on terms at least as favorable as those on which such person is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 1526 of the Act by §7531. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under §7531.

B. The exemption of a transaction pursuant to §7531 with respect to the participation therein of one party thereto shall not render such transaction exempt with respect to participation of any other party therein unless such other party also meets the conditions of §7531.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7533. Exemption from Section 1526 of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar Plans

A. Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operations of Section 1526 of the *Act* if the plan meets the following conditions.

1. The plan has been approved, directly or indirectly:

a. by the affirmative votes of the holders of a majority of the securities of such insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the state of Louisiana; or

b. by the written consent of the holders of a majority of the securities of such insurer entitled to vote; provided, however, that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the Commissioner of Insurance in effect at the time of such vote or written consent, the insurer shall furnish, in writing, to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of:

i. the date the Act first applies to such insurer; or

ii. the acquisition of an equity security for which exemption is claimed. Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with, or mailed for filing to the commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this Paragraph, the term *insurer* includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

2. If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as follows.

a. With respect to the participation of directors:

i. by the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

ii. by, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

iii. otherwise in accordance with the plan, if the plan:

(a). specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or

(b). sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

b. With respect to the participation of officers who are not directors:

i. by the board of directors of the insurer or a committee of three or more directors; or

ii. by, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

c. For the purpose of §7533.A.2, a director or committee member shall be deemed to be a disinterested person only if such person is not at the time such discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock of qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

d. The provisions of §7533.A.2 shall not apply with respect to any option granted, or other equity security acquired, prior to the date that Sections 1525, 1526 and 1527 of the Act first become applicable with respect to any class of equity securities of any insurer.

3. As to each participant, or as to all participants, the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

4. Unless the context otherwise requires, all terms used in §7533 shall have the same meaning as in the Act and in Subchapter A of these regulations. In addition, the following definitions apply.

Exercise of an Option, Warrant or Right—contained in the parenthetical clause of §7533.A shall not include:

i. the making of any election to receive under any plan an award of compensation in the form of stock or credits therefor, provided that such election is made prior to the making of the award, and provided further that such election is irrevocable until at least six months after termination of employment;

ii. the subsequent crediting of such stock;

iii. the making of any election as to a time for delivery of such stock after termination of employment, provided that such election is made at least six months prior to any such delivery;

iv. the fulfillment of any condition to the absolute right to receive such stock; or

v. the acceptance of certificates for shares of such stock.

Plan—includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

Qualified Stock Option and *Employee Stock Purchase Plan* that are set forth in Sections 422 and 423 of the *Internal Revenue Code of 1954*, as amended, are to be applied to those terms where used in §7533.

Restricted Stock Option—as defined in Section 424(b) of the *Internal Revenue Code of 1954*, as amended, shall be applied to that term as used in §7533, provided, however, that for the purposes of §7533 an option which meets all of the conditions of that Section, other than the date of issuance shall be deemed to be a *restricted stock option*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7535. Exemption from Section 1526 of Certain Transactions in which Securities are Received by Redeeming other Securities

A. Any acquisition of an equity security (other than a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of Section 2 of the Act upon condition that:

1. the equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets other than cash (or government bonds) consist of securities of the insurer issuing the equity security so acquired, and which:

a. represented substantially and in practical effect a stated or readily ascertainable amount of such equity security;

b. had a value which was substantially determined by the value of such equity security; and

c. conferred upon the holder the right to receive such equity security without the payment of any consideration other than the security redeemed;

2. no security of the same class as the security redeemed was acquired by the director or officer within six months prior to such redemption or is acquired within six months after such redemption;

3. the insurer issuing the equity security acquired has recognized the applicability of §7535.A.1 by appropriate corporate action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7537. Exemption of Long-Term Profits Incident to Sales within Six Months of the Exercise of an Option

A. To the extent specified in §7537.B, the commissioner hereby exempts as not comprehended within the purposes of Section 1526 of the Act any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where such purchase is pursuant to the exercise of an option or similar right either:

1. acquired more than six months before its exercise; or

2. acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

B. In respect of transactions specified in §7537.A the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in §7537 shall be deemed to enlarge the amount of profit which would inure to such insurer in the absence of §7537.

C. The commissioner also hereby exempts, as not comprehended within the purposes of Section 1526 of the Act, the disposition of a security, purchased in a transaction specified in §7537.A, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in Section 368(c) of the *Internal Revenue Code of 1954*, of a person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

D. The exemptions provided by §7537 shall not apply to any transaction made unlawful by Section 1527 of the Act or by any rules and regulations thereunder.

E. The burden of establishing market price of a security for the purpose of §7537 shall rest upon the person claiming the exemption.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7539. Exemption from Section 1526 of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidations

A. The following transactions shall be exempt from the provisions of Section 1526 of the Act as not comprehended within the purpose of said Section.

1. The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company.

2. The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company.

3. The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by reference to their most recent available financial statements for a 12-month period prior to the merger or consolidation.

4. The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a 12-month period prior to the merger or consolidation.

B. A merger within the meaning of §7539 shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

C. Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by §7539) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by §7539) of a security in any other company involved in the merger or consolidation within any period of less than six months during which the merger or consolidation took place, the exemption provided by §7539 shall be unavailable to such officer, director, or stockholder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7541. Exemption from Section Two of Certain Securities Received upon Surrender of Similar Equity Securities

A. Any acquisition or disposition of an equity security involved in the deposit of such security under, or the withdrawal of such security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing such security, shall be exempt from the operation of Section 2 of the Act if substantially all of the assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal, as the case may be, consisted of equity securities of the same class as the security deposited or withdrawn; provided, however, that §7541 shall not apply to the extent that there shall have been either:

1. a purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class; or

2. a sale of an equity security of the class deposited and a purchase of any certificate representing an equity security of such class (otherwise than in a transaction involved in such deposit or withdrawal or in a transaction exempted by any other provision of the regulations under Section 2 of the Act) within a period of less than six months, which includes the date of the deposit or withdrawal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7543. Exemption from Section Two of Certain Transactions Involving an Exchange of Similar Securities

A. Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of Section 2 of the Act; provided, however, that §7543 shall not apply to the extent that there shall have been either:

1. a purchase of any equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion; or

2. a sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion (otherwise than in a transaction involved in such conversion or in a transaction exempted by any other provision of the regulations under Section 2 of the Act) within a period of less than six months, which includes the date of conversion.

B. For the purpose of §7543, an equity security shall not be deemed to be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with such conversion, of cash or other property (other than equity securities involved in the conversion) equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

C. For the purpose of §7543, an equity security shall be deemed convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of the security or the governing instruments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

Subchapter D. Regulations under Section 1527 of the Act

§7549. Exemption of Certain Securities from Section 1527 of the Act

A. Any security shall be exempt from the operation of Section 1527 of the Act to the extent necessary to render lawful under such Section the execution by a broker of an order for an account in which he has no direct or indirect interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7551. Exemption from Section 1527 of the Act of Certain Transactions Effected in Connection with a Distribution

A. Any security shall be exempt from the operation of Section 1527 of the Act to the extent necessary to render lawful under such Section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions.

1. The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends, in good faith, to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting-dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons.

2. Other persons not within the purview of Section 1527 of the Act are participating in the distribution of such block of securities on terms at least as favorable as those on which such dealer is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 1527 of the Act by §7551. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under §7551.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7553. Exemption from Section 1527 of the Act of Sales of Securities to be Acquired

A. Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed", the security to be acquired shall be exempt from the operation of Section 1527, provided that:

1. the sale is made subject to the same conditions as those attaching to the right of acquisition; and

2. such person exercises reasonable diligence to deliver such security to the purchaser promptly after his right of acquisition matures; and

3. such person reports the sale on the appropriate form for reporting transactions by persons subject to Section 1525 of the Act.

B. Section 7553 shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when-issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

Subchapter E. Regulation under Section 1529 of the Act

§7559. Arbitrage Transactions under Section 1529 of the Act

A. It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of such insurer, unless he shall include such transaction in the statements required by Section 1525 of the Act and shall account to such insurer for the profits arising from such transaction, as provided in Section 1526 thereof. The provisions of Section 1527 shall not apply to such arbitrage transactions. The provisions of the Act shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than such director or officer of the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7561. Form A

A. Instructions

1. Persons Required to File Statements

a. A statement on this form is required to be filed by every person who is directly or indirectly the beneficial owner of more than 10 percent of any equity security of a domestic stock insurance company, or who is a director or an officer of such a company.

2. When Statements Are to Be Filed

a. Persons who hold any of the relationships specified in §7561.A.1.a are required to file a statement by July 1, 1966, or within 10 days after assuming such relationship, whichever date is later.

b. Statements are not deemed to have been filed with the commissioner until they have actually been received by him.

3. Where Statements Are to Be Filed

a. One signed copy of each statement shall be filed with the Commissioner of Insurance, P. 0. Box 44214, Baton Rouge, Louisiana.

4. Separate Statement for Each Company

a. A separate statement shall be filed with respect to the securities of each company.

5. Relationship of Reporting Person to Company

a. Indicate clearly the relationship of the reporting person to the company, for example, "Director", "Director and Vice President", "Beneficial owner of more than 10 percent of the company's common stock", etc.

6. Date as of which Beneficial Ownership Is to Be Given

a. The information as to beneficial ownership of securities shall be given as of July 1, 1966, or in the case of persons who subsequently assume any of the relationships specified in §7561.A.1.a, as of the date that relationship was assumed.

7. Title of Security

a. The statement of the title of a security shall be such as clearly to identify the security, even though there may be only one class, for example, "Class A Common Stock", "Common Stock", etc.

8. Nature of Ownership

a. Under "Nature of Ownership", state whether ownership of the securities is "direct" or "indirect". If the ownership is indirect (i.e., through a partnership, corporation, trust or other entity) indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

9. Statement of Amount Owned

a. In stating the amount of securities beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote or other appropriate manner, the extent of his interest in the partnership, corporation, trust or other entity.

10. Inclusion of Additional Information. A statement may include any additional information or explanation deemed relevant by the person filing the statement.

11. Signature. If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

B. Form

STATE OF LOUISIANA
COMMISSIONER OF INSURANCE
BATON ROUGE

DUDLEY A. GUGLIELMO
COMMISSIONER

FORM A

INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Filed pursuant to Act ____Eight____ of 1966

_____
(Name of Insurance Company)

_____
(Name of person whose ownership is required)

_____
(Business address of such person: street, city, zone, state)

Relationship of such person to company named above. (See instruction 5.) _____

_____

Date of event which requires the filing of this statement. (See instruction 6.) _____

SECURITIES BENEFICIALLY OWNED

TITLE OF SECURITY (See instruction 7)	NATURE OF OWNERSHIP (See instruction 8)	AMOUNT OWNED (See instruction 9)

REMARKS: (See instruction 9.)

I affirm under penalty of perjury that the foregoing is full, true and correct.

Date of Statement_____ _____
(Signature)

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

§7563. Form B

A. Instructions

1. Persons Required to File Statements

a. Statements on this form are required to be filed by every person who at any time during any calendar month was directly or indirectly the beneficial owner of more than 10 percent of any class of equity security of a domestic stock insurance company, or a director or officer of the company which is the issuer of such securities, and who during such month had any change in his beneficial ownership of any class of equity security of such company.

2. When Statements Are to Be Filed

a. Statements are required to be filed on or before the tenth day after the end of each month in which any change in beneficial ownership has occurred. Statements are not deemed to have been filed with the commissioner until they have actually been received by him.

3. Where Statements Are to Be Filed

a. One signed copy of each statement shall be filed with the Commissioner of Insurance, P. 0. Box 44214, Baton Rouge, Louisiana.

4. Separate Statement for Each Company

a. A separate statement shall be filed with respect to the securities of each company.

5. Relationship of Reporting Person to Company

a. Indicate clearly the relationship of the reporting person to the company, for example, "Director", "Director and Vice President", "Beneficial owner of more than 10 percent of the company's common stock", etc.

6. Transactions and Holdings to Be Reported

a. Every transaction shall be reported even though purchases and sales during the month are equal or the change involves only the nature of ownership, for example, from direct to indirect ownership. Beneficial ownership at the end of the month of all classes of securities required to be reported shall be shown even though there has been no change during the month in the ownership of securities of one or more classes.

7. Title of Security

a. The statement of the title of the security shall be such as clearly to identify the security even though there may be only one class, for example, "Class A Common Stock", "Common Stock", etc.

8. Date of Transaction

a. The exact date (month, day and year) of each transaction shall be stated opposite the amount involved in the transaction.

9. Statement of Amounts of Securities

a. In stating the amount of the securities acquired, disposed of, or beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly (i.e., through a partnership, corporation, trust or other entity) the entire amount of securities involved in the transaction or owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote or other appropriate manner, the extent of his interest in the transaction or holdings of the partnership, corporation, trust or other entity.

10. Nature of Ownership

a. Under "Nature of Ownership", state whether ownership of the securities is "direct" or "indirect". If the ownership is indirect (i.e., through a partnership, corporation, trust or other entity) indicate in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

11. Character of Transaction

a. If the transaction was with the issuer of the securities, so state. If it involved the purchase of securities through the exercise of options, so state and give the exercise price per share. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character (for example, gift, 5 percent stock dividend, etc.), as the case may be. The foregoing information may be appropriately set forth in the table or under "Remarks" at the end of the table.

12. Inclusion of Additional Information

a. A statement may include any additional information or explanation deemed relevant by the person filing the statement.

13. Signature

a. If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specifically on his behalf by a person authorized to sign for him.

B. Form

STATE OF LOUISIANA
COMMISSIONER OF INSURANCE
BATON ROUGE

INSIDER TRADING

DUDLEY A. GUGLIELMO
COMMISSIONER

FORM B

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES

Filed pursuant to Act ___Eight___ of 1966

_____
(Name of insurance company)

_____
(Name of person whose ownership is required)

_____
(Business address of such person: street, city, zone, state)

Relationship of such person to company named above. (See instruction 5) _____

_____

Statement for Calendar Month of _____, 20_____

CHANGES DURING MONTH AND MONTH-END OWNERSHIP (See instruction 6.)

TITLE OF SECURITY (See instruction 7)	DATE OF TRANSACTION (See instruction 8)	AMOUNT BOUGHT or otherwise acquired (See instruction 9)	AMOUNT SOLD or otherwise disposed of (See instruction 9)	NATURE OF OWNERSHIP (See instruction 10)	AMOUNT OWNED beneficially at end of month (See instruction 9)

REMARKS: (See instructions 11 and 12)

I affirm under penalty of perjury that the foregoing is full, true, and correct.

_____

_____

Date of Statement_____

(Signature)_____

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 1, 1966, amended April 1, 1967.

Chapter 77. Regulation 28—Variable Contract Regulation

§7700. Authority

A. This regulation is adopted and promulgated by the Department of Insurance pursuant to the authority granted by R.S. 22:1500 and the Administrative Procedure Act, R.S. 49:950 et seq. This regulation replaces and repeals the regulation of similar purpose which took effect on January 1, 1969.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:67 (January 1998).

§7701. Definition

Agent—any person, corporation, partnership, or other legal entity which, under the laws of this state, is licensed as an insurance agent.

Company—any insurer which possesses a certificate of authority to conduct life insurance business or annuity business in the state of Louisiana.

Contract on a Variable Basis or *Variable Contract*—any policy or contract which provides for annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, as provided for in R.S. 22:1500.

Variable Contract Agent—an agent who shall sell or offer to sell any contract on a variable basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:67 (January 1998).

§7703. Qualification of Insurance Companies to Issue Variable Contracts

A. No company shall deliver or issue for delivery variable contracts within this state unless the commissioner is satisfied that its condition and method 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. The commissioner shall consider the following in making such a determination:

1. the history and financial condition of the company;

2. the character, responsibility, and fitness of the officers and directors of the company; and

3. the law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

B. A company's subsidiary or affiliate, by common management or ownership, may be deemed by the commissioner to have satisfied the provisions of Paragraph A.2 of this Section if either the company or its subsidiary or affiliate satisfies the provisions of Paragraph A.2 of this Section, provided, further, that companies having a satisfactory record of doing business in this state for a period of at least three years may be deemed to have satisfied the commissioner with respect to Paragraph A.2 of this Section.

C. Before any company shall deliver or issue for delivery variable contracts, it shall submit to the commissioner:

1. a general description of the kinds of variable contracts it intends to issue;

2. if requested by the commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue variable contracts; and

3. if requested by the commissioner, biographical data with respect to officers and directors of the company.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:68 (January 1998).

§7705. Separate Account or Separate Accounts

A. A domestic company issuing variable contracts shall establish one or more separate accounts pursuant to R.S. 22:1500.

1. 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 as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided that the portion of the assets of such separate account equal to the company's reserve liability with regard to the benefits guaranteed as to amount and duration, and funds guaranteed as to principal amount or stated rate of interest shall be valued in accordance with the rules otherwise applicable to the company's asset.

2. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

3.a. Notwithstanding any other provision of law, a company may:

i. with respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust, exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably, as determined by the company; or

ii. with respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably, as determined by the company. Such committee, board, or other

body may have the power, exercisable alone or in conjunction with others, to manage such separate account and the investment of its assets.

b. A company, committee, board, or other body may make such other provisions in respect to any such separate account as may be deemed appropriate to facilitate compliance with requirements of any federal or state law now or hereafter in effect, provided that the commissioner approves such provisions as not hazardous to the public or the company's policyholders in this state.

4. No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made:

a. by a transfer of cash; or

b. by a transfer of securities having a valuation which could be readily determined in the marketplace, and provided that such transfer of securities is approved by the commissioner. The commissioner may authorize other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

5. The company shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account, except as may otherwise be approved by the commissioner.

6. Rules under any provision of R.S. 22:1500 or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee, board, or other similar body. No officers or directors of such company nor any member of the committee, board, or separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:68 (January 1998).

§7707. Filing of Contracts

A. The filing requirements applicable to variable contracts shall be those filing requirements otherwise applicable under existing statutes and regulations of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:69 (January 1998).

§7709. Contracts Providing for Variable Benefits

A. Any variable contract delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of benefits. Any such contract providing benefits which vary during the payment period, including a group contract and any certificate issued thereunder, shall state that the periodic payments will vary to reflect investment experience and shall contain, on its first page, a clear statement to the effect that the periodic payments thereunder are on a variable basis. Any such contract which provides values which are vested in an annuitant under an individual contract or in the holder of a certificate under a group contract prior to the commencement of the payment period, which values will vary to reflect investment experience, shall state that such values are on the variable basis. Any certificate issued under a group contract providing such variable values shall also contain the statements required by the preceding sentence. If any such contract provides such variable periodic payments, as well as such variable values, the statements required by the preceding sentences may be combined.

B. Illustrations of benefits payable under any variable contract shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of annuity payments.

C.1. Any individual variable annuity contract delivered or issued for delivery in this state shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and may guarantee that expenses and/or mortality results shall not adversely affect such dollar amounts. If not guaranteed, the expense and morality factors shall also be stipulated in the contract.

2. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

a. the annual net investment increment assumption shall not exceed 5 percent, except with the approval of the commissioner;

b. to the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the commissioner, from another table.

3. *Expense*, as used in this Subsection, may exclude some or all taxes, as stipulated in the contract.

4. Variable annuity contracts delivered or issued for delivery in this state may include as an incidental benefits provision for payment on death during the deferred period of an amount not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or

the value of the contract at the time of death; such provisions will not be deemed to be contracts of life insurance and therefore not subject to the provisions of the Insurance Law governing life insurance. Provision for any other benefit on death during the deferred period will be subject to such insurance provisions.

5. The reserve liability for variable annuities shall be established pursuant to the requirements of the standard valuation law, in accordance with actuarial procedures that recognize the variable nature of the benefits provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:69 (January 1998).

§7711. Required Reports

A. Any company issuing individual variable contracts providing benefits in variable amounts shall mail to the contract holder, at least once in each contract year after the first, at his last address known to the company, a statement or statements reporting the investments held in the separate account, and in the case of contracts under which payments have not yet commenced, a statement reporting as of a date not more than four months previous to the date of mailing:

1. the number of accumulation units credited to such contracts and the dollar value of a unit; or

2. the value of the contract holder's account.

B. The company shall submit annually to the insurance commissioner a statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:69 (January 1998).

§7713. Foreign Companies

A. If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these regulations, the commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:69 (January 1998).

§7715. Licensing of Agents and Other Persons

A.1. No agent shall be eligible to sell or offer for sale a contract on a variable basis unless, prior to making any solicitation or sale of such a contract, that agent is licensed to sell life insurance in this state and presents evidence of satisfactorily passing one of the following written examinations upon securities and variable contracts:

a. any state securities examination accepted by the Securities and Exchange Commission;

b. the National Association of Securities Dealers, Inc. examination for principals or examination for qualification as a registered representative;

c. the various securities examinations required by the New York Stock Exchange, the American Stock Exchange, the Pacific Stock Exchange, or any other registered national securities exchange;

d. the Securities and Exchange Commission test given pursuant to Section 15(b)(8) of the Securities Exchange Act of 1934.

2. Any agent who participates only in the sale or offering for sale of variable contracts that are not registered under the Federal Securities Act of 1933 need not be licensed as a variable contract agent.

3. Any agent applying for a license as a variable contract agent shall do so by filing an application. All applications for a license shall be in writing on uniform forms prescribed by the Commissioner of Insurance.

B. Any applicant for license as a variable contract agent shall present evidence that the applicant is currently registered with the Federal Securities and Exchange Commission as a broker-dealer or is currently associated with a broker-dealer and has met qualification requirements with respect to such association.

C. Except as modified by this regulation, refer to Part XXIV and Insurance Regulations of this department governing the licensing of life insurance agents.

D. Any person licensed in this state as a variable contract agent shall immediately report to the commissioner:

1. any suspension or revocation of the agent's variable contract license or life insurance license in any other state or territory of the United States;

2. the imposition of any disciplinary sanctions (including the suspension or expulsion from membership, suspension or revocation of or denial of registration) imposed upon him/her by the National Securities Exchange, The National Securities Association, or any federal, state, or territorial agency with jurisdiction over securities or contracts on a variable basis;

3. any judgment or injunction entered against him/her on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

E. The commissioner may reject any application or suspend, revoke, or refuse to renew any agent's variable contract license upon any ground that would bar such applicant or such agent from being licensed to sell life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's life insurance license shall also govern any proceeding for suspension or revocation of an agent's variable contract license.

F. An agent's variable contract license shall be renewed annually upon the approval of a variable contract agent appointment. A certificate of license status dated within 90 days must be submitted with the appointment for any nonresident agent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1500 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, January 1969, amended LR 24:69 (January 1998).

Chapter 79. Regulation 29—Correlated Sales of Life Insurance and Equity Products

§7901. Purpose

A. This directive is for the purpose of establishing minimum standards for the form of proposals and statements used to solicit, service, or collect premiums for life insurance which is sold in connection with any equity product which is registered with the Federal Securities and Exchange Commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7903. Applicability

A. This directive shall apply:

1. to acts and practices in the advertising, promotion, solicitation, negotiation of or effecting the sale of:

a. life insurance policies (which term shall include annuity contracts for the purpose of Regulation 29) in correlation with the sale of equity products;

b. contracts which contemplate the purchase of a life insurance policy in correlation with the sale of equity products;

2. to any acts and practices, whether they involve the use of language disseminated by means of sales kits, policy jackets or covers, letters, personal presentations, visual aids and other sales media in connection with the solicitation, sale, servicing or collection of premiums for life insurance in correlation with equity products, engaged in by any insurance company, agent, or person as defined in R.S. 22:1212.

B. As used in this directive, in referring to sales of insurance and equity products described in R.S. 22:1214(11), the terms "correlated sales" or "sales in connection with" shall include, but not be limited to, the following:

1. sales of insurance and equity products as part of an integrated plan;

2. sales in which both life insurance and equity products are offered as part of the same investment program;

3. sales programs in which both life insurance and equity products are discussed and their purchase solicited during the same interview.

C. As used in this directive, the words *equity products* are defined as mutual funds, shares of investment companies, variable annuities, and face amount certificates of regulated investment companies, all of which are registered with the federal securities and exchange commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7905. Statement of Policy

A. There shall be full disclosure of relevant facts in the sale of life insurance in correlation with the sale of equity products. Accordingly, this rule sets forth certain proposed procedures and requirements establishing minimum standards for disclosure of information in sales of life insurance and equity products.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7907. Responsibility of Company and Agent

A. No insurance company, agent, or person to whom this rule applies shall make, in connection with correlated sales of life insurance and equity products, a proposal or billing other than in accordance with the requirements of this directive. Every such company must inform its agents of the requirements of this directive.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7909. Tie-In Sales

A. The agent, at the commencement of, and throughout the sales presentation, must fully disclose to the purchaser that he has the right to purchase life insurance only, equity products only, or both life insurance and equity products.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7911. Written Proposal

A. In any solicitation of an offer to buy, or in any sale of life insurance in correlation with the sale of equity products, the prospect or policyholder must be furnished a copy of a clear and unambiguous written proposal not later than at the time the solicitation or proposal is made. A copy of such written proposal shall be kept on file by the agent, or by the company if no agent is involved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7913. Contents of Proposal

A. Any proposal referred to in this directive must:

1. be dated and signed by the insurance agent;

2. state the name and the company in which the life insurance is to be written;

3. state that the purchaser has the right to purchase life insurance only, equity products only, or both life insurance and equity products;

4. contain no misrepresentation or false, deceptive or misleading words, figures or statements. It must be accurate and complete and state all facts without which the proposal would have the capacity or tendency to mislead or deceive;

5. show the premium charged for life insurance separately from any other charge;

6. if values which may accrue prior to the death of the insured are involved in the presentation, show the value of the life insurance policy separately from any other values;

7. show, if it is involved in the presentation, the amount of the death benefit for the life insurance separately from any other benefit which any accrue upon the death of the insured;

8. set forth all matters pertaining to life insurance separately from any matter not pertaining to life insurance;

9. set forth policy numbers, name of company, face values and cash values of all existing policies of the insured, which are to be surrendered if the proposal is accepted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7915. Statement to Be Separate

A. Any bill, statement, draft, or representation sent or delivered to any prospect or policyholder must show the premium charged for the life insurance and any other information mentioned concerning life insurance separate from any other charge or value shown in the same billing, but nothing in §7915 shall prevent the total of the premium charge for life insurance with any other charge or value shown in the same billing to arrive at the total billing charge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7917. Maintenance of File by Company

A. File of Advertising and Other Sales Material. Each insurance company to whom this rule applies shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement, advertisement material, sales literature and sales aid of any other kind used in connection with the correlated sale of life insurance and equity products as may hereafter be prepared or disseminated in this state, with a notation attached to each such piece of material which shall indicate the manner and extent of distribution, the nature of use and the form number of any policy issued in connection with such correlated plan and such document. Such file shall be subject to regular and periodic inspection by the Department of Insurance of the state of Louisiana. All such material shall be maintained in the file for a period of not less than three years.

B. Certificate of Compliance. Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of Regulation 29 must be file with this department, together, with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisement, advertising material, sales literature and sales aids which were disseminated by the insurer during the preceding statement year comply or were made to comply in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this directive.

C. Companies in violation of this directive shall be subject to having their certificate of authority to transact business in Louisiana revoked or suspended, and agents in violation of this rule shall be subject to having their agent's license suspended or revoked or a fine not to exceed $500 levied for each violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

§7919. Effective Date

A. This directive shall become effective March 1, 1969.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, March 1, 1969.

Chapter 81. Regulation 30—Certificates of Insurance Coverage

§8101. Certificates of Insurance

A. It has come to the attention of this department that certificates of insurance for automobile and general liability insurance are being executed by companies or their agents. certificates of insurance are pre-printed forms that many large corporations require persons or contractors employed by them to furnish to prove that they have insurance.

B. Some of these certificates purport to enlarge or vary the policy of insurance involved. When this is attempted, it is in violation of Louisiana Revised Statute 22:620 which requires that companies obtain approval of all endorsements that are used in the state of Louisiana.

C. Therefore, in order to avoid any misunderstanding of the effect of any certificate of insurance signed by an insurance company or its agent, any such certificate must contain the following or similar language:

This certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by Policy Number _____ issued by _____.

D. Companies shall inform their agents of the contents of this regulation. Please acknowledge receipt of this regulation promptly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, April 23, 1969.

Chapter 83. Regulation 35—Variable Life Insurance Model Regulation

§8301. Definitions

A. As used in Regulation 35:

Affiliate of an Insurer—any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of any such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

Agent—any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent.

Assumed Investment Rate—the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

Benefit Base—the amount to which the net investment return is applied.

Commissioner—the Insurance Commissioner of this state.

Control (including the terms *controlling, controlled by*, and *under common control with*)—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 any person, directly or indirectly, owns, controls, holds with power to vote, or holds proxies representing more than 10 percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Flexible Premium Policy—any variable life insurance policy other than a scheduled premium policy as specified in the definition of *scheduled premium policy.*

General Account—all assets of the insurer other than assets in separate accounts established pursuant to Section 1500 of the insurance laws of this state, or pursuant to the corresponding Section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

Incidental Insurance Benefit—all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to, accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term, riders.

May—is permissive.

Minimum Death Benefit—the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy, regardless of the investment performance of the separate account.

Net Investment Return—the rate of investment return in a separate account to be applied to the benefit base.

Person—an individual, corporation, partnership, association, trust, or fund.

Policy Processing Day—the day on which charges authorized in the policy are deducted from the policy's cash value.

Scheduled Premium Policy—any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

Separate Account—a separate account established pursuant to Section 1500 of the Insurance Laws of this state or pursuant to the corresponding Section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

Shall—is mandatory.

Variable Death Benefit—the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

Variable Life Insurance Policy—any individual policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to Section 1500 of the Insurance Laws of this state or pursuant to the corresponding Section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:694 (July 1985).

§8303. Qualification of Insurer to Issue Variable Life Insurance

A. The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or having authority to issue variable life insurance in this state.

1. Licensing and Approval to Do Business in This State

a. An insurer shall not deliver or issue for delivery in this state any variable life insurance policy unless:

i. the insurer is licensed or organized to do a life insurance business in this state;

ii. the insurer has obtained the written approval of the commissioner for the issuance of variable life insurance policies in this state. The commissioner shall grant such written approval only after he has found that:

(a). the plan of operation for the issuance of variable life insurance policies is not unsound;

(b). the general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable life insurance business of the insurer in this state; and

(c). the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider, among other things:

(i). the history of operation and financial condition of the insurer;

(ii). the qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(iii). the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies. The state of entry of an alien insurer shall be deemed its state of domicile for this purpose; and

(iv). if the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

2. Filing for Approval to Do Business in This State

a. The commissioner may, at his discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this state, file with this department the following information for the consideration of the commissioner in making the determination required by §8303.A.1:

i. copies of and a general description of the variable life insurance policies it intends to issue;

ii. a general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of policies and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial or distribution services to the insurer;

iii. with respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the issuer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy shall include a description of the investment objectives intended for the separate account;

iv. a description of any investment advisory services contemplated as required by §8309.A.10;

v. a copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies; and

vi. biographical data with respect to officers and directors of the insurer on the National Association of Insurance Commissioners Uniform Biographical Data Form; and

vii. a statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

3. Standards of Suitability

a. Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the Standards of Suitability to be used by the insurer. Such Standards of Suitability shall specify that no recommendations shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

4. Use of Sales Materials

a. An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material, or descriptive literature or

other materials of any kind in connection with its variable life insurance business in this state which is false, misleading, deceptive, or inaccurate.

5. Requirements Applicable to Contractual Services

a. Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the commissioner with any information or reports in connection with such services which the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations and any other applicable law or regulations.

6. Reports to the Commissioner

a. Any insurer authorized to transact the business of variable life insurance in this state shall submit to the commissioner, in addition to any other materials which may be required by this regulation or any other applicable laws or regulations:

i. an annual statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners; and

ii. prior to the use in this state any information furnished to applicants as provided for in §8311; and

iii. prior to the use in this state, the form of any of the reports to policyholders, as provided for in §8315; and

iv. such additional information concerning its variable life insurance operations or its separate accounts as the commissioner shall deem necessary.

b. Any material submitted to the commissioner under §8303.A.6 shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the commissioner shall require the distribution of amended material.

7. Authority of Commissioner to Disapprove

a. Any material required to be filed with and approved by the commissioner shall be subject to disapproval if at any time it is found by him not to comply with the standards established by Regulation 35.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:695 (July 1985).

§8305. Insurance Policy Requirements

A. Policy Qualification. The commissioner shall not approve any variable life insurance form filed pursuant to Regulation 35 unless it conforms to the requirements of §8305.

1. Filing of Variable Life Insurance Policies

a. All variable life insurance policies, and all riders, endorsements, applications and other documents which are to be attached to and made a part of the policy and which relate to the variable nature of the policy, shall be filed with the commissioner and approved by him prior to delivery or issuance for delivery in this state.

i. The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with Regulation 35, the same as those otherwise applicable to other life insurance policies.

ii. The commissioner may approve variable life insurance policies and related forms with provisions the commissioner deems to be not less favorable to the policyholder and the beneficiary than those required by Regulation 35.

2. Mandatory Policy Benefit and Design Requirements

a. Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements.

i. Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

ii. For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid (subject to the provisions of §8305.A.4);

iii. The policy shall reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the variable life insurance policy is actuarially sound.

iv. Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

v. Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

vi. The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other non-forfeiture benefits, as described either in the policy or in a statement filed with the commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other non-forfeiture benefits must be at least equal to the minimum values required by Section 168 of the Insurance Laws of this state for a general account policy with such premiums and benefits. The assumed investment rate shall

not exceed the maximum interest rate permitted under the Standard Non-Forfeiture Law of this state. If the policy does not contain an assumed investment rate this demonstration shall be based on the maximum interest rate permitted under the Standard Non-forfeiture Law. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

vii. The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the commissioner.

3. Mandatory Policy Provisions

a. Every variable life insurance policy filed for approval in this state shall contain at least the following.

i. The cover page or pages corresponding to the cover pages of each such policy shall contain:

(a). a prominent statement in either contrasting color or in boldface type that the amount or duration of death benefits may be variable or fixed under specified conditions;

(b). a prominent statement in either contrasting color or in boldface type that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees;

(c). a statement describing any minimum death benefit required pursuant to §8305.A.2.a.ii;

(d). the method, or a reference to the policy provision which describes the method, for determining the amount of insurance payable at death;

(e). to the extent permitted by state law, a captioned provision that the policyholder may return the variable life insurance policy within 10 days of receipt of the policy by the policyholder, and receive a refund equal to the sum of:

(i). the difference between the premiums paid including any policy fees or other charges and the amounts allocated to any separate accounts under the policy; and

(ii). the value of the amounts allocated to any separate accounts under the policy, on the date the returned policy is received by the insurer or its agent. Until such time as state law authorizes the return of payments as calculated in the preceding sentence, the amount of the refund shall be the total of all premium payments for such policy;

(f). such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with Regulation 35.

ii.(a). For scheduled premium policies, a provision for a grace period of not less than 31 days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(b). For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than 61 days after the mailing date of the Report to Policyholders required by §8315.A.3.

(i). The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing days occur monthly, the insurer may require the payment of not more than three times the charges which were due on the policy processing day on which the amounts available under the policy were insufficient to pay all charges authorized by the policy that are necessary to keep such policy in force until the next policy processing day.

iii. For scheduled premium policies, a provision that the policy will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(a). all overdue premiums with interest at a rate not exceeding 6 percent per annum compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate as provided in Section 170.1;

(b). 110 percent of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding 6 percent per annum compounded annually.

iv. A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy.

v. A provision designating the separate account to be used and stating that:

(a). the assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account;

(b). the assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

vi. A provision specifying what documents constitute the entire insurance contract under state law.

vii. A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his behalf, shall be considered as representations and not warranties.

viii. An identification of the owner of the insurance contract.

ix. A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation.

x. A statement of any conditions or requirements concerning the assignment of the policy.

xi. A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured.

xii. A provision that the policy shall be incontestable by the insurer after it has been in force for two years during the lifetime of the insured, provided, however, that any increase in the amount of the policy's death benefits subsequent to the policy issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, shall be incontestable after any such increase has been in force, during the lifetime of the insured, for two years from the date of issue of such increase.

xiii. A provision stating that the investment policy of the separate account shall not be changed without the approval of the Insurance Commissioner of the state of domicile of the insurer, and that the approval process is on file with the commissioner of this state.

xiv. A provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(a). for up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account; or

(b). otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical.

xv. If settlement options are provided, at least one such option shall be provided on a fixed basis only.

xvi. A description of the basis for computing the cash value and the surrender value under the policy shall be included.

xvii. Premiums or charges for incidental insurance benefits shall be stated separately.

xviii. Any other policy provision required by this regulation.

xix. Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this regulation.

xx. A provision for non-forfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any non-forfeiture insurance options will not be available.

4. Policy Loan Provisions

a. Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than the following:

i. a provision for policy loans after the policy has been in force for two full years which provides the following:

(a). at least 75 percent of the policy's cash surrender value may be borrowed;

(b). the amount borrowed shall bear interest at a rate not t exceed that permitted by state insurance law;

(c). any indebtedness shall be deducted from the proceeds payable on death;

(d). any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any non-forfeiture benefit;

(e). for scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within 31 days after the date of mailing of such notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next following processing day exceed the amounts available under the policy to pay such charges, a report must be sent to the policyholder containing the information specified by §8315.A.3;

(f). the policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount, not exceeding 110 percent of the corresponding increase, in cash value and by furnishing such evidence of insurability as the insurer may request;

(g). the policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision;

(h). no policy loan provision is required if the policy is under extended insurance non-forfeiture option;

(i). the policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof;

(j). amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amounts for policy loans from the general account.

5. Other Policy Provisions

a. The following provision may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

i. an exclusion for suicide within two years of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may provide an exclusion for suicide within two years of any increase in death benefits which results from an application of the owner subsequent to the policy issue date;

ii. incidental insurance benefits may be offered on a fixed or variable basis;

iii. policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition, such policies may offer the following dividend options:

(a). the amount of the dividend may be credited against premium payments;

(b). the amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(c). the amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(d). the amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance;

(e). the amount of the dividend may be deposited as a variable deposit in a separate account;

iv. a provision allowing the policyholder to elect, in writing, in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under §8305.A.4, except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed;

v. a provision allowing the policyholder to make partial withdrawals;

vi. any other policy provision approved by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:696 (July 1985).

§8307. Reserve Liabilities for Variable Life Insurance

A. Reserve liabilities for variable life insurance policies shall be established under the Standard Valuation Law in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

B. For scheduled premium policies, reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

1. the aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate; or

2. the aggregate total of the attained age level reserves on each variable life insurance contract. The attained age level reserve on each variable life insurance contract shall not be less than zero and shall equal the residue, as described in §8307.B.2.a, of the prior year's attained age level reserve on the contract, with any such residue, increased or decreased by a payment computed on an attained age basis, as described in §8307.B.2.b:

a. the residue of the prior year's attained age level reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest at the valuation interest rate to such prior years' reserve, deducting the tabular claims based on the excess, if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The excess referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year;

b. the payment referred to in §8307.B.2 shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to (A) minus (B) minus (C), where (A) is the present value of the future guaranteed minimum death benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (C) is any residue, as described in §8307.B.2.a, of the prior year's attained age level reserve on such variable life insurance contract. If the contract is paid-up, the payment shall equal (A) minus (B) minus (C). The amounts of future

death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life contracts;

3. the valuation interest rate and mortality table used in computing the two minimum reserves described in (a) and (b) above shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

C. For flexible premium policies, reserve liabilities for any guaranteed minimum death benefit shall be maintained in the general account of the insurer and shall be not less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate.

1. The valuation interest rate and mortality table used in computing this additional reserve, if any, shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates including, but not limited to, groupings and averages.

D. Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:698 (July 1985).

§8309. Separate Accounts

A. The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer.

1. Establishment and Administration of Separate Accounts

a. Any domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to Section 1500 of the Insurance Laws of this state.

i. If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets shall be in writing and the commissioner shall have authority to review and approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

ii. Such insurer shall not, without the prior written approval of the commissioner, employ in any material connection with the handling of separate account asset any person who:

(a). within the last 10 years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Section 1341, 1342, or 1343 of Title 18, United States Code; or

(b). within the last 10 years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(c). within the last 10 years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

iii. All persons with access to the cash, securities, or other assets of the separate account shall be under bond in the amount of not less than a value indexed to the NAIC fidelity bonding recommendations regarding personnel handling general account assets.

iv. The assets of such separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

2. Amounts in the Separate Account

a. The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

3. Investments by the Separate Account

a. No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

i. in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

ii. such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

b. The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

4. Limitations on Ownership

a. A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by

the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by these regulations, would exceed 10 percent of the value of the assets of the separate account. The commissioner may waive this limitation, in writing, if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

b. No separate account shall purchase or otherwise acquire the voting securities of any issuer if, as a result of such acquisition, the insurer and its separate accounts, in the aggregate, will own more than 10 percent of the total issued and outstanding voting securities of such issuer. The commissioner may waive this limitation, in writing, if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state or jeopardize the independent operation of the issuer of such securities.

c. The percentage limitation specified in §8309.A.4.a shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of §8309.A.3 and other applicable portions of Regulation 35.

5. Valuation of Separate Account Assets

a. Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

6. Separate Account Investment Policy

a. The investment policy of a separate account operated by a domestic insurer filed under §8303.A.2.a.iii shall not be changed without first filing such change with the Insurance Commissioner.

i. Any change filed pursuant to §8309 shall be effective 60 days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such 60-day period of his disapproval of the proposed change. At any time the commissioner may, after notice and public hearing, disapprove any change that has become effective pursuant to §8309.

ii. The commissioner may disapprove the change if he determined that the change would be detrimental to the interests of the policyholders participating in such separate account.

7. Charges against Separate Account

a. The insurer must disclose, in writing, prior to or contemporaneously with delivery of the policy, all charges that may be made against the separate account including, but not limited to, the following:

i. taxes or reserves for taxes attributable to investment gains and income of the separate account;

ii. actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

iii. actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

iv. charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

v. a charge, at a rate specified in the policy, for mortality and expense guarantees;

vi. any amounts in excess of those required to be held in the separate accounts;

vii. charges for incidental insurance benefits.

8. Standards of Conduct

a. Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its Board of Directors a written statement specifying the Standards of Conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such Standards of Conduct shall be binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17j under the Investment Company Act of 1940 and applicable rules and regulations thereunder shall satisfy the provisions of §8309.

9. Conflicts of Interest

a. Rules under any provision of the Insurance Laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

10. Investment Advisory Services to a Separate Account

a. An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

i. the person providing such advice is registered as an investment adviser under the Investment Advisers Act of 1940; or

ii. the person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

iii. the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed adviser:

(a). the name and form of organization, state of organization, and its principal place of business;

(b). the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, of such individual;

(c). a written Standard of Conduct complying in substance with the requirements of §8309.A.8, which has been adopted by the investment adviser and is applicable to the investment adviser, his officers, directors, and affiliates;

(d). a statement provided by the proposed adviser as to whether the adviser or any person associated therewith:

(i). has been convicted within 10 years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director or an insurance company, a banker, an insurance agent, a securities broker, or an investment adviser involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of Sections 1341, 1342, or 1343 of Title 18 of United States Code;

(ii). has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment adviser, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii). has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under any such laws; or

(iv). has been censured, denied an investment adviser registration, had a registration as an investment adviser revoked or suspended, or been barred or suspended from being associated with an investment adviser by order of federal or state regulatory authorities; and

iv. such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than 60 days' written notice to the investment adviser.

b. The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:699 (July 1985).

§8311. Information Furnished to Applicants

A. An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of §8311 shall be deemed to have been satisfied to the extent that a disclosure containing information required by §8311 is delivered, either in the form of:

1. a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or

2. all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof:

a. a summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation. Such explanation must include notices of the provision required by §8305.A.3.a.i.(e) and §8305.A.3.a.vi;

b. a statement of the investment policy of the separate account, including:

i. a description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

ii. any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted;

c. a statement of the net investment return of the separate account for each of the last ten years or such lesser period as the separate account has been in existence;

d. a statement of the charges levied against the separate account during the previous year;

e. a summary of the method to be used in valuing assets held by the separate account;

f. a summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary;

g. illustrations of benefits payable under the variable life insurance contract. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:701 (July 1985).

§8313. Applications

A. The application for a variable life insurance policy shall contain:

1. a prominent statement that the death benefit may be variable or fixed under specified conditions;

2. a prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);

3. questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:701 (July 1985).

§8315. Reports to Policyholders

A. Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports.

1. Within 30 days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, any optional payments allowed pursuant to §8305.A.4 under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within 30 days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than 60 days prior to the mailing of such notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by §8315. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. In addition, the report must show the projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that:

a. planned periodic premiums, if any, are paid as scheduled;

b. guaranteed costs of insurance are deducted; and

c. the net investment return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

2. Annually, a statement or statements including:

a. a summary of the financial statement of the separate account based on the annual statement last filed with the commissioner;

b. the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years, when available;

c. a list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the commissioner;

d. any charges levied against the separate account during the previous year;

e. a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment adviser of the separate account.

3. For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of such amount.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:701 (July 1985).

§8317. Foreign Companies

A. If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially similar to that provided by these regulations, the commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:702 (July 1985).

§8319. Life Insurance

A. Qualification to Sell Variable Life Insurance

1. No person may sell or offer for sale in this state any variable life insurance policy unless such person is an agent and has filed with the commissioner, in a form satisfactory to the commissioner, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable life insurance.

2. Any examination administered by the department for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation, and sale of variable life insurance as the commissioner deems appropriate.

B. Reports of Disciplinary Actions. Any person qualified in this state under §8319 to sell or offer to sell variable life insurance shall immediately report to the commissioner:

1. any suspension or revocation of his agent's license in any other state or territory of the United States;

2. the imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance;

3. any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

C. Refusal to Qualify Agent to Sell Variable Life Insurance: Suspension, Revocation, or Nonrenewal of Qualification

1. The commissioner may reject any application or suspend or revoke or refuse to renew any agent's qualification under §8319 to sell or offer to sell variable life insurance upon any ground that would bar such applicant or such agent from being licensed to sell other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell to offer to sell variable life insurance.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:702 (July 1985).

§8321. Severability

A. If any provision of item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation which can be given effect without the invalid provisions, item, or application.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 of the Insurance Laws of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:702 (July 1985), amended by Louisiana Legislature, House Concurrent Resolution Number 135 of the 2001 Regular Session, LR 27:1102 (July 2001).

Chapter 85. Regulation 36—Universal Life Insurance Model Regulation

§8501. Purpose

A. The purpose of this regulation is to supplement existing regulations on life insurance policies in order to accommodate the development and issuance of universal life insurance plans.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8503. Definitions

A. As used in Regulation 36:

Cash Surrender Value—the Net Cash Surrender Value plus any amounts outstanding as policy loans.

Commissioner—the Insurance Commissioner of this state.

Fixed Premium Universal Life Insurance Policy—a universal life insurance policy other than a flexible premium universal life insurance policy.

Flexible Premium Universal Life Insurance Policy—a universal life insurance policy which permits the policyowner to vary, independently of each other, the amount or timing of one or more premium payments or the amount of insurance.

Interest-Indexed Universal Life Insurance Policy—any universal life insurance policy where the interest credits are linked to an external referent.

May—is permissive.

Net Cash Surrender Value—the maximum amount payable to the policyowner upon surrender.

Policy Value—the amount to which separately identified interest credits and mortality, expense, or other charges are made under a universal life insurance policy.

Shall—is mandatory.

Universal Life Insurance Policy—any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8505. Scope

A. This regulation encompasses all individual universal life insurance policies except those policies defined under Article 11, Section 19 of the NAIC Model Variable Life Insurance Regulation.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8507. Valuation

A. Requirements

1. The minimum valuation standard for universal life insurance policies shall be the Commissioners Reserve Valuation Method, as described below for such policies, and the tables and interest rates specified below. The terminal reserve for the basic policy and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less (C) and (D), where:

a. reserves by the net level premium method shall be equal to:

((A)-(B))r

where:

(A), (B), and "r" are as defined below:

(A) is the present value of all future guaranteed benefits at the date of valuation.

(B) is the quantity: $\frac{PVFB}{\ddot{a}_x}$ $\ddot{a}_{x+t}$

where:

PVFB is the present value of all benefits guaranteed at issue assuming future Guaranteed Maturity Premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer.

$\ddot{a}_x$ and $\ddot{a}_{x+t}$ are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and x+t, respectively, and continuing until the highest attained age at which a premium may be paid under the policy. The letter "x" is defined as the issue age and the letter "t" is defined as the duration of the policy.

The Guaranteed Maturity Premium for flexible premium universal life insurance policies shall be that level gross premium, paid at issue and periodically thereafter over the period during which premiums are allowed to be paid, which will mature the policy on the latest maturity date, if any, permitted under the policy (otherwise at the highest age in the valuation mortality table), for an amount which is in accordance with the policy structure.[1] The Guaranteed Maturity Premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees.[2]

The letter "r"

is equal to one, unless the policy is a flexible premium policy and the policy value is less than the Guaranteed Maturity Fund, in which case "r" is the ratio of the policy value to the Guaranteed Maturity Fund.

The Guaranteed Maturity Fund at any duration is the amount which, together with future Guaranteed Maturity Premiums, will mature the policy based on all policy guarantees at issue.

(C) is the quantity ((a)-(b) $\ddot{a}_{x+tr}$ where (a)-(b) is as described in Section Four of the Standard Valuation Law, as amended in 1980 for the plan of insurance defined at issue by the Guaranteed Maturity Premiums and all guarantees contained in the policy or declared by the insurer.

$\ddot{a}_{x+t}$ and $\ddot{a}_x$ are defined in (B) above.

(D) is the sum of any additional quantities analogous to (C) which arise because of structural changes[3] in the policy, with each such quantity being determined on a basis consistent with that of (C) using the maturity date in effect at the time of the change.

The Guaranteed Maturity Premium, the Guaranteed Maturity Fund and (B) above shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the descriptions above.

b. Future guaranteed benefits are determined by:

i. projecting the greater of the Guaranteed Maturity Fund and the policy value, taking into account future Guaranteed Maturity Premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and

ii. taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

c. All present values shall be determined using:

i. an interest rate (or rates) specified by the Standard Valuation Law (as amended in 1980) for policies issued in the same year;

ii. the mortality rates specified by the Standard Valuation Law, as amended in 1980 for policies issued in the same year or contained in such other table as may be approved by the Commissioner for this purpose; and

iii. any other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

[1]The maturity amount shall be the initial death benefit where the death benefit is level over the lifetime of the policy except for the existence of a minimum-death-benefit corridor, or, shall be the specified amount where the death benefit equals a specified amount plus the policy value or cash surrender value except for the existence of a minimum-death-benefit corridor.

[2]The Guaranteed Maturity Premium for both flexible and fixed premium policies shall be adjusted for death benefit corridors provided by the policy. The Guaranteed Maturity Premium may be less than the premium necessary to pay all charges. This can especially happen in the first year for policies with large first year expense charges.

[3]Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyowner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

B. Alternative Minimum Reserves

1. If, in any policy year, the Guaranteed Maturity Premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of Subparagraphs a or b.

a. The reserve calculated according to the method, the mortality table, and the rate of interest actually used.

b. The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the Guaranteed Maturity Premium in each policy year for which the valuation net premium exceeds the Guaranteed Maturity Premium.

2. For universal life insurance reserves on a net level premium basis, the valuation net premium is:

$$\frac{PVFB}{\ddot{a}_x}$$

3. and for reserves on a Commissioner's Reserve Valuation Method, the valuation net premium is:

$$\frac{PVFB}{\ddot{a}_x} + \frac{(a) - (b)}{\ddot{a}_x}.$$

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8509. Nonforfeiture

A. Minimum Cash Surrender Values for Flexible Premium Universal Life Insurance Policies

1. Minimum cash surrender values for flexible premium universal life insurance policies shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

2. The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to the accumulation to that date as of which interest is credited to the policy shall be equal to the accumulation to that date of the premiums paid minus the accumulations to that date of:

a. the benefit charges;

b. the averaged administrative expense charges for the first policy year and any insurance increase years;

c. actual administrative expense charges for other years;

d. initial and additional acquisition expense charges not exceeding the initial or additional expense allowances, respectively;

e. any service charges actually made (excluding charges for cash surrender or election of a paid-up nonforfeiture benefit); and

f. any deductions made for partial withdrawals; all accumulations being at the actual rate or rates of interest at which interest credits have been made unconditionally to the policy (or have been made conditionally, but for which the conditions have since been met), and minus any unamortized unused initial and additional expense allowances.

3. Interest on the premiums and on all charges referred to in §8509.A.2.a-f shall be accumulated from and to such dates as are consistent with the manner in which interest is credited in determining the policy value.

4. The benefit charges shall include the charges made for mortality and any charges made for riders or supplementary benefits for which premiums are not paid separately. If benefit charges are substantially level by duration and develop low or no cash values, then the commissioner shall have the right to require higher cash values unless the insurer provides adequate justification that the cash values are appropriate in relation to the policy's other characteristics.[4]

5. The administrative expense charges shall include charges per premium payment, charges per dollar of premium paid, periodic charges per thousand dollars of insurance, periodic per policy charges, and any other charges permitted by the policy to be imposed without regard to the policyowner's request for services.

6. The averaged administrative expense charges for any year shall be those which would have been imposed in that year if the charge rate or rates for each transaction or period within the year had been equal to the arithmetic average of the corresponding charge rates which the policy states will be imposed in policy years 2 through 20 in determining the policy value.

7. The initial acquisition expense charges shall be the excess of the expense charges, other than service charges actually made in the first policy year over the averaged administrative expense charges for that year. Additional acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in an insurance-increase year over the averaged administrative expense charges for that year. An insurance-increase year shall be the year beginning on the date of increase in the amount of insurance by policyowner request (or by the terms of the policy).

8. Service charges shall include charges permitted by the policy to be imposed as the result of a policyowner's request for a service by the insurer (such as the furnishing of future benefit illustrations) or of special transactions.

9. The initial expense allowance shall be the allowance provided by [Items (ii), (iii) and (iv) of Section 5] or by [Items (ii) and (iii) of Section 5-c(l)], as applicable, of the *Standard Non-Forfeiture Law for Life Insurance, as amended in 1980* for a fixed premium, fixed benefit endowment policy with a face amount equal to the initial face amount of the flexible premium universal life insurance policy, with level premiums paid annually until the highest attained age at which a premium may be paid under the flexible premium universal life insurance policy, and maturing on the latest maturity date permitted under the policy, if any, otherwise at the highest age in the valuation

mortality table. The unused initial expense allowance shall be the excess, if any, of the initial expense allowance over the initial acquisition expense charges, as defined above.

10. If the amount of insurance is subsequently increased upon request of the policyowner (or by the terms of the policy), an additional expense allowance and an unused additional expense allowance shall be determined on a basis consistent with the above and with [Section 5-c(5) of the *Standard Nonforfeiture Law for Life Insurance, as amended in 1980*, using the face amount and the latest maturity date permitted at that time under the policy.

11. The unamortized unused initial expense allowance during the policy year beginning on the policy anniversary at age x + t (where "x" is the same issue age) shall be the unused initial expense allowance multiplied by:

$$\frac{\ddot{a}_{x}+t}{\ddot{a}_{x}}$$

where:

$\ddot{a}_x$ + t and $\ddot{a}_x$ + t and $\ddot{a}_x$ are present values of an annuity of one per year payable on policy anniversaries beginning at ages x + t and x, respectively, and continuing until the highest attained age at which a premium may be paid under the policy, both on the mortality and interest bases guaranteed in the policy. An unamortized unused additional expense allowance shall be the unused additional expense allowance multiplied by a similar ratio of annuities, with $\ddot{a}_x$ replaced by an annuity beginning on the date as of which the additional expense allowance was determined.

[4]Because this product is still developing, it is recommended that benefit charges not be restricted and regulatory treatment of cash values be limited to that contained in this Section for several reasons.
First, further restrictions would limit the development of the product.
Second, added restrictions would discourage insurers from reducing non-guaranteed current benefit charges because such reductions could require reduced future benefit charges that could be financially unsound for the insurer.
Third, market pressures will encourage insurers to limit benefit charges.

B. Minimum Cash Surrender Values for Fixed Premium Universal Life Insurance Policies

1. For fixed premium universal life insurance policies, the minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

a. The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to:

((A)-(B)-(C)-(D))

where:

(A) is the present value of all future guaranteed benefits.

(B) is the present value of future adjusted premiums. The adjusted premiums are calculated as described in (Sections 5 and 5-a or in Paragraph (1) of Section 5-c], as applicable, of the Standard Nonforfeiture Law for Life Insurance, as amended in 1980. If Section 5-c, Paragraph (1) is applicable, the nonforfeiture net level premium is equal to the quantity:

$$\frac{PVFB}{\ddot{a}_{x}}$$

where:

PVFB is the present value of a benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer.

$\ddot{a}_x$ is the present value of an annuity of one per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy.

(C) is the present value of any quantities analogous to the nonforfeiture net level premium which arise because of guarantees declared by the insurer after the issue date of the policy. $\ddot{a}_x$ shall be replaced by an annuity beginning on the date as of which the declaration became effective and payable until the end of the period covered by the declaration.

(D) is the sum of any quantities analogous to (B) which arise because of structural changes[5] in the policy.

b. Future guaranteed benefits are determined by:

i. projecting the policy value taking into account future premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and

ii. taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

c. All present values shall be determined using:

i. an interest rate (or rates) specified by the Standard Nonforfeiture Law for Life Insurance, as amended in 1980 for policies issued in the same year; and

ii. the mortality rates specified by the Standard Nonforfeiture Law for Life Insurance, as amended in 1980 for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose.

[5]See Footnote 3 (§8507)

C. Minimum Paid-Up Nonforfeiture Benefits

1. If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, it shall be such that its present value shall be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value shall be based on mortality and interest standards at least as favorable to the policyowner as:

a. in the case of a flexible premium universal life insurance policy, the mortality and interest basis guaranteed in the policy for determining the policy value; or

b. in the case of fixed premium policy the mortality and interest standards permitted for paid-up nonforfeiture benefits by *the Standard Nonforfeiture Law for Life Insurance, as amended in 1980*. In lieu of the paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than 60 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.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8511. Mandatory Policy Provisions

A. The policy shall provide the following.

1. Periodic Disclosure to Policyowner

a. The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised as to the status of the policy. The end of the current report period must be not more than three months previous to the date of the mailing of the report. Specific requirements of this report are detailed in §8515.

2. Illustrative Reports

a. The policy shall provide for an illustrative report which will be sent to the policyowner upon request. Minimum requirements of such report are the same as those set forth in §8513. The insurer may charge the policyowner a reasonable fee for providing the report.

3. Policy Guarantees

a. The policy shall provide guarantees of minimum interest credits and maximum mortality and expense charges. All values and data shown in the policy shall be based on guarantees. No figures based on nonguarantees shall be included in the policy.

4. Calculation of Cash Surrender Values

a. The policy shall contain at least a general description of the calculation of cash surrender values including the following information:

i. the guaranteed maximum expense charges and loads;

ii. any limitation on the crediting of additional interest. Interest credits shall not remain conditional for a period longer than 24 months;

iii. the guaranteed minimum rate or rates of interest;

iv. the guaranteed maximum mortality charges;

v. any other guaranteed charges;

vi. any surrender or partial withdrawal charges.

5. Changes in Basic Coverage

a. If the policyowner has the right to change the basic coverage, any limitation on the amount or timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the policy shall state whether a new period of contestability and/or suicide is applicable to the additional coverage.

6. Grace Period and Lapse

a. The policy shall provide for written notice to be sent to the policyowner's last known address at least 30 days prior to termination of coverage.

b. A flexible premium policy shall provide for a grace period of at least 30 days (or as required by state statute) after lapse. Unless otherwise defined in the policy, lapse shall occur on that date on which the net cash surrender value first equals zero.

7. Misstatement of Age or Sex. If there is a misstatement of age or sex in the policy, the amount of the death benefit shall be that which would be purchased by the most recent mortality charge at the correct age or sex. The commissioner may approve other methods which are deemed satisfactory.

8. Maturity Date. If a policy provides for a maturity date, end date, or similar date, then the policy shall also contain a statement, in close proximity to that date, that it is possible that coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner, if such is the case.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8513. Disclosure Requirements

A. In connection with any advertising, solicitation, negotiation, or procurement of a universal life insurance policy:

1. any statement of policy cost factors or benefits shall contain:

a. the corresponding guaranteed policy cost factors or benefits, clearly identified;

b. a statement explaining the nonguaranteed nature of any current interest rates, charges, or other fees applied to the policy, including the insurer's rights to alter any of these factors;

c. any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited.

2. Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value.

3. Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined.

4. If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy.

5. Any illustrated benefits based upon nonguaranteed interest, mortality, or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed.

6. If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy's maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8515. Periodic Disclosure to Policyowner

A. Requirements

1. The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised of the status of the policy. The end of the current report period shall be not more than three months previous to the date of the mailing of the report.

2. Such report shall include the following:

a. the beginning and end of the current report period;

b. the policy value at the end of the previous report period and at the end of the current report period;

c. the total amounts which have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

d. the current death benefit at the end of the current report period on each life covered by the policy;

e. the net cash surrender value of the policy as of the end of the current report period;

f. the amount of outstanding loans, if any, as of the end of the current report period;

g. for fixed premium policies: if, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report;

h. for flexible premium policies: If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

§8517. Interest-Indexed Universal Life Insurance Policies

A. Initial Filing Requirements

1. The following information shall be submitted in connection with any filing of interest-indexed universal life insurance policies (interest-indexed policies). All such information received shall be treated confidentially to the extent permitted by law:

a. a description of how the interest credits are determined, including:

i. a description of the index;

ii. the relationship between the value of the index and the actual interest rate to be credited;

iii. the frequency and timing of determining the interest rate;

iv. the allocation of interest credits, if more than one rate of interest applies to different portion of the policy value;

b. the insurer's investment policy, which includes a description of the following:

i. how the insurer addressed the reinvestment risks;

ii. how the insurer plans to address the risk of capital loss on cash outflows;

iii. how the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities;

iv. how the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy;

v. the amount and type of assets currently held for interest indexed policies;

vi. the amount and type of assets expected to be acquired in the future;

c. if policies are linked to an index for a specified period less than to the maturity date of the policy, a description of the method used (or currently contemplated) to determine interest credits upon the expiration of such period;

d. a description of any interest guarantee in addition to or in lieu of the index;

e. a description of any maximum premium limitations and the condition under which they apply.

B. Additional Filing Requirements

1. Annually, every insurer shall submit a statement of actuarial opinion by the insurer's actuary similar to the example contained in §8517.C.

2. Annually, every insurer shall submit a description of the amount and type of assets currently held by the insurer with respect to its interest-indexed policies.

3. Prior to implementation, every domestic insurer shall submit a description of any material change in the insurer's investment strategy or method of determining the interest credits. A change is considered to be material if it would affect the form or definition of the index (i.e., any change in the information supplied in §8517.A) or if it would significantly change the amount or type of assets held for interest-indexed policies.

C. Statement of Actuarial Opinion for Interest-Indexed Universal Life Insurance Policies

I _____ am _____
(Name) (Position or Relationship to Insurer)

for the XYZ Life Insurance Company (The Insurer) in the state of _____.
(State of Domicile of Insurer)

I am a member of the American Academy of Actuaries (or if not, state other qualifications to sign annual statement actuarial opinions).

I have examined the interest-indexed universal life insurance policies of the Insurer in force as of December 31, ____, encompassing _____ number of policies and $_____ of insurance in force.

I have considered the provisions of the policies. I have considered any reinsurance agreements pertaining to such policies, the characteristics of the identified assets and the investment policy adopted by the Insurer as they affect future insurance and investment cash flows under such policies and related assets. My examination included such tests and calculations as I considered necessary to form an opinion concerning the insurance and investment cash flows arising from the policies and related assets.

I relied on the investment policy of the Insurer and on projected investment cash flows as provided by Chief Investment Officer of the Insurer.[6]

The tests were conducted under various assumptions as to future interest rates, and particular attention was given to those provisions and characteristics that might cause future insurance and investment cash flows to vary with changes in the level of prevailing interest rates.

In my opinion, the anticipated insurance and investment cash flows referred to above make good and sufficient provision for the contractual obligations of the Insurer under these insurance policies.

_____
Signature of Actuary

[6]If the actuary does not choose to rely on an investment officer for the projected investment cash flows, this statement should be modified to show the extent of the actuary's reliance.

AUTHORITY NOTE: Promulgated in accordance with Title 22, Section 2 and Title 36, Section 682 of the Insurance Laws of the State of Louisiana.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 11:690 (July 1985).

Chapter 87. Regulation 69—Year 2000 Exclusions

Editor's Note: The Notices in §§8719, 8723 and 8725 should use the name of the current Commissioner of Insurance, James J. Donelon, and the telephone number 342-0896 should be removed.

Subchapter A. General Provisions

§8701. Authority

A. This regulation is adopted pursuant to R.S. 22:2 which charges the Commissioner of Insurance with the duty to enforce and administer all of the provisions of the Insurance Code, the purpose of which is to regulate the business of insurance in all of its phases in the public interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1256 (July 1999).

§8703. Purpose

A. The purpose of this regulation is to set parameters on the use of Y2K exclusions and endorsements in order to protect the public interest and to assure the continued viability of the insurance market in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1256 (July 1999).

§8705. Scope and Applicability

A. The scope of application of this regulation differs depending on whether the insurer is an admitted insurer or a surplus lines insurer.

B. Admitted Insurers. Except for Subchapter C, this regulation applies to all admitted property and casualty insurance companies engaged in the business of insurance in this state and governs the use of Y2K exclusions whether issued before, on or after its effective date. It governs all Y2K exclusions affecting contracts of insurance delivered or issued for delivery in this state by admitted insurers which cover property risks or liability risks located in this state, or are to be performed in Louisiana regardless of where made or delivered.

C. Surplus Lines Insurers. Surplus lines insurers must comply with Subchapter C of this regulation. Subchapter B does not apply to surplus line insurers.

(Former Subsection C is now the last sentence in Subsection A.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3., R.S. 22:941, R.S. 22:1262 and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner LR 25:1256 (July 1999), amended LR 26:86 (January 2000).

§8707. Severability

A. If any Section or provision of this regulation is held invalid, such invalidity shall not affect other Sections of provisions which can be given effect without the invalid Section or provision, and for this purpose the Sections and provisions of this regulation are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1256 (July 1999).

§8709. Definitions

A. For the purposes of this regulation the following terms shall have the meaning ascribed herein.

Admitted Insurers—any and all property and casualty insurers authorized to do business in this state pursuant to a Certificate of Authority duly issued by the Commissioner of Insurance for the state of Louisiana.

Commissioner—the Commissioner of Insurance for the state of Louisiana.

Economic Loss—losses arising out of business transactions.

File and Use—the filing of forms which may then be used by the insurer without receiving prior approval, subject to the LDOI's right of review and right to disallow continued use of the forms.

LDOI—the Louisiana Department of Insurance and/or the Commissioner of Insurance.

LIRC—the Louisiana Insurance Rating Commission.

Surplus Lines Insurers—insurers placed on the list of approved unauthorized insurers maintained by the Commissioner of Insurance for the state of Louisiana in accordance with R.S. 22:1262.1.

Y2K—the year 2000 anno Domini.

Y2K Exclusion—all exclusions and endorsements developed by the insurance industry, including but not limited to the ISO forms, to address coverage issues raised by the Y2K problem whether they are captioned *Y2K* or use terminology such as *date recognition*, *computer related*, *electronic data*.

Y2K Problem—the inability of computers and other electronic systems including embedded chips to accurately process, provide and/or receive date data from, into, and between the twentieth and twenty first centuries due to a programming design which causes the system to read "00" as 1900 not 2000. The term *Y2K problem* also includes problems resulting from the leap year calculation, date recognition problems attributed to the Global Positioning System arising on or after August 22, 1999 and the programming of 9/9/99 to read end of field or to delete data.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1256 (July 1999), amended LR 26:86 (January 2000).

§8711. Forms Approval

A. Y2K exclusions are hereby exempted from the requirement that they be approved prior to use. Such exclusions may be submitted on a "file and use" basis if the filing complies with §8713 of this regulation. Pending filings must be reviewed by the filer to determine compliance. If the original filing does not comply with this regulation the filing must be corrected and resubmitted. Authorization to issue Y2K exclusions expires on January 1, 2002. This Section applies only to insurers required by law to file forms with the commissioner. This exemption applies only to forms. Rate and rule filings must be made with the LIRC as required by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:620E.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1257 (July 1999).

Subchapter B. Admitted Insurers

§8713. Underwriting Standards

A. Except as provided herein, Y2K exclusions may not be used on a blanket basis. This standard applies to both property and liability coverage. Exclusions should not be used where the insured makes or has made a good faith effort to resolve any Y2K problems on its property or where the insured has demonstrated compliance with Y2K criteria established by the insurer.

1. Personal Lines. Y2K exclusions are not approved for use in personal lines, including homeowner policies, farm owner policies and personal umbrella policies, except for business pursuits coverage. A Y2K exclusion may be used in connection with a personal lines policy's business coverage only if the company can document that there is a realistic risk of exposure which warrants the use of a Y2K exclusion. The underwriting documentation must be maintained in the insured's file for a period of five years from the date of issuance of the exclusion. If a Y2K exclusion is attached to the business pursuits portion of a personal line policy it must provide coverage for ensuing perils otherwise covered by the policy and it must have an exception for on premises bodily injury.

2. Commercial Lines (including but not limited to Commercial Property, Boiler and Machinery, Commercial Auto, General Liability, Professional Liability, Directors and Officers and Business Owners).

a. Property Coverage. ISO's IL 09 35, FP 10 21 and BP 10 04 may be used on a mandatory basis as filed and approved. Y2K exclusions with substantially similar language and which provide coverage for ensuing perils (notwithstanding language in the policy which could be interpreted to the contrary such as "indirectly, concurrently caused, or regardless of other causes") may also be used in

the same manner as ISO exclusions. But, because potential Y2K property exposures are definable and measurable hazards a filing which substantially deviates from the ISO exclusions referenced above must justify the conclusion that there is no impact on premium or specify the premium reduction to be given insureds in exchange for attaching the exclusion.

b. Y2K exclusions which do not contain language stating that ensuing perils are covered may not be used in Louisiana. If approval was granted to a Y2K exclusion in conflict with this provision, the approval is hereby withdrawn.

3. Liability Coverage. Use of Y2K exclusions with liability coverage is strongly discouraged and should be limited to those insureds which have failed to take adequate steps to correct their Y2K problem or which have excessive exposure to outside contamination. "Total" Y2K exclusions, such as ISO's CG 21 60, should be limited to high risk insureds. For other classes, Y2K exclusions which have an exception for bodily injury or which provide for the scheduling of risks and perils, such as ISO's CG 21 63 and CG 21 64, should be used.

a. And, except as provided below, Y2K exclusions may not be used for the following classes of risks: mercantile and restaurants, lodging and habitational, or institutional, such as churches and schools.

b. Y2K exclusions which provide for the scheduling of risks and perils, such as ISO's CG 21 63 and CG 21 64, may be used with a subclasses of the classes stated in the above paragraph if the insurer identifies and justifies the exposure to be excluded or limited in the specific subclass. An insurer attaching a Y2K exclusion to an individual risk within such a subclass must maintain documentation in the underwriting file of each individual risk that identifies and justifies the exposure presented by that particular risk; and, maintain documentation that the insurer has provided loss control information to the insured. This documentation must be maintained in the insured's file for a period of five years from the date of issuance of the exclusion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. R.S. 22:1211 et seq., R.S. 22:941, R.S. 22:1262 and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1257 (July 1999), repromulgated LR 26:86 (January 2000).

§8715. Monitoring of Market Conduct

A. Each admitted insurer must file with the LIRC a list identifying the classes it has determined warrant the use of Y2K exclusion. The filing must contain the criteria used in determining that a particular class of business should be included on the list and identify the type of exclusion which it may use with each class. If an insurer issues a "total" Y2K exclusion (such as ISO's CG 21 60) to a risk within the filed classes it must be able to provide documentation upon request which identifies and justifies the exposure presented by that particular risk. If the list filed with the LIRC contains a subclass of any of the following classes, the insurer must still comply with the requirements imposed by §8713: mercantile and restaurants, lodging and habitational, or institutional, such as churches and schools.

B. Any admitted insurer, which denies coverage or issues a reservation of rights letter to an insured based in toto or in part upon a Y2K exclusion in the policy must notify the LDOI. The notice must be provided to the LDOI within 15 days of the denial of coverage or issuance of the reservation of rights letter. A copy of the denial of coverage letter or reservations of rights letter is sufficient notice.

C. The LDOI will closely monitor the use of Y2K exclusions to make certain that they are not used inappropriately by admitted insurers in underwriting or claims handling. Examples of inappropriate activity are:

1. blanket use of Y2K exclusions;

2. failure to individually underwrite except when authorized by this regulation;

3. denial of claims inconsistent with underwriting standards;

4. canceling or nonrenewing coverage as a general business practice;

5. widespread unavailability of "buy back" coverage; and

6. unsupported blanket denial of claims based upon "lack of fortuity", or the "known risk" and/or "expected or intended" exclusions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. R.S. 22:1211 et seq., R.S. 22:941, R.S. 22:1215, R.S. 22:1262, R.S. 22:1262.1. R.S. 22:1301 and R.S. 22:1404.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1257 (July 1999), amended LR 26:86 (January 2000).

§8717. Representations and Warranties

A. No representation or warranty may defeat coverage or be used to deny a claim by an admitted insurer unless the representation or warranty is (a) material (b) false) and (c) made with the intent to deceive. Questionnaires used to assess Y2K exposure are subject to this standard. Denial of coverage by an admitted insurer on the grounds that an answer in a questionnaire is erroneous or inadequate, in the absence of fraud, will result in disciplinary action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3. R.S. 22:619 and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1258 (July 1999), amended LR 27:87 (January 2000).

§8719. Notice

A. No insurance policy may be issued or renewed, by an admitted insurer, with a Y2K exclusion unless the insured is provided with a copy of the Y2K Notice prepared by the LDOI. (The text of the Notice can be found in §8719.C.)

B. Notice for renewals must be provided by an admitted insurer not less than 60 days in advance to the insured and the agent of record.

C. Below is the notice required by this Section.

1. Below is the Y2K Notice required by §8719. Issuance of this notice is mandatory. However, insurers are not precluded from issuing their own notices in conjunction with this notice.

2. Formatting Instructions. The caption must be in large type and in bold. The text of the notice should be formatted as shown below and should be in a font of not less than 12 point type.

IMPORTANT NOTICE FROM (COMPANY) AND THE LOUISIANA DEPARTMENT OF INSURANCE

PLEASE READ IT!

***

A NEW ENDORSEMENT HAS BEEN ATTACHED TO YOUR POLICY. THE NEW ENDORSEMENT DEALS WITH THE "Y2K" PROBLEM.

USE OF THIS ENDORSEMENT IS GOVERNED BY LOUISIANA DEPARTMENT OF INSURANCE REGULATION 69.

IF YOU HAVE ANY QUESTIONS ABOUT THE ENDORSEMENT OR THE REGULATION YOU MAY CONTACT THE LOUISIANA DEPARTMENT OF INSURANCE AT THE ADDRESS LISTED BELOW:

COMMISSIONER JAMES H. "JIM" BROWN
LOUISIANA INSURANCE BUILDING
950 NORTH FIFTH STREET
BATON ROUGE, LA 70802

OR BY TELEPHONE
342-5900, 342-0895, OR 342-0896
1-800-259-5300 OR 1-800-359-5301

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1258 (July 1999), amended LR 26:87 (January 2000).

§8721. Exemptions

A. Lines of Coverage. If the commissioner finds that the application of this regulation unduly hinders the availability of coverage for a particular line of insurance he may, by written order, grant an exemption for so long as he deems proper.

B. Individual Insureds. An exemption may be granted upon written notification to the LDOI by an admitted insurer regarding an individual policyholder which poses an extraordinary risk due to its failure to take any steps to remedy its Y2K problem. Documentation that demonstrates the necessity for the exemption must be maintained in the insureds file for a period of five years from the date of issuance of the exclusion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1258 (July 1999), amended LR 26:87 (January 2000).

Subchapter C. Surplus Lines Insurers

§8723. Mandatory Policyholder Notice

A. Every insurance contract issued or delivered as a surplus line coverage in this state, as provided in Part XXVII.Chapter 1 of Title 22 of the Louisiana Revised Statues, which has a Y2K exclusion shall have attached to it the Policyholder Notice found in Subsection C of this Section. Insurers are not precluded from issuing their own notices in conjunction with the mandatory notice.

B. Formatting Instructions. The caption must be in large type and in bold. The text of the notice should be formatted as shown below and should be in a font of not less than 12 point type.

C. Policyholder Notice Text

IMPORTANT NOTICE FROM (COMPANY) AND THE LOUISIANA DEPARTMENT OF INSURANCE

PLEASE READ IT!

***

A NEW ENDORSEMENT HAS BEEN ATTACHED TO YOUR POLICY. THE NEW ENDORSEMENT DEALS WITH THE "Y2K" PROBLEM.

USE OF THIS ENDORSEMENT IS GOVERNED BY LOUISIANA DEPARTMENT OF INSURANCE REGULATION 69.

IF YOU HAVE ANY QUESTIONS ABOUT THE ENDORSEMENT OR THE REGULATION YOU MAY CONTACT THE LOUISIANA DEPARTMENT OF INSURANCE AT THE ADDRESS LISTED BELOW:

COMMISSIONER JAMES H. "JIM" BROWN
LOUISIANA INSURANCE BUILDING
950 NORTH FIFTH STREET
BATON ROUGE, LA 70802

OR BY TELEPHONE
342-5900, 342-0895, OR 342-0896
1-800-259-5300 OR 1-800-359-5301

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3,. and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:87 (January 2000).

§8725. Claims Notice

A. Every surplus lines insurer which denies coverage of a claim on the grounds that the claim is excluded in whole or in part by the policy's Y2K exclusion shall provide the insured and the claimant, if the claimant is not an insured, the notice found in Subsection C of this Section.

B. Formatting Instructions. The caption must be in large type and in bold. The text of the notice should be formatted as shown below and should be in a font of not less than 12 point type.

C. Claim Notice Text

IMPORTANT NOTICE FROM THE LOUISIANA DEPARTMENT OF INSURANCE

PLEASE READ IT!

***

POLICY No. _____

CLAIMANT: _____

CLAIM No. _____

COVERAGE FOR THIS CLAIM HAS BEEN DENIED BECAUSE YOUR INSURER HAS DETERMINED THAT THE Y2K ENDORSEMENT ATTACHED TO THE POLICY EXCLUDES COVERAGE FOR THIS TYPE OF LOSS.

IF YOU QUESTION THE DENIAL OF COVERAGE, YOU MAY CONTACT THE LOUISIANA DEPARTMENT OF INSURANCE AT THE ADDRESS LISTED BELOW:

COMMISSIONER JAMES H. "JIM" BROWN
LOUISIANA INSURANCE BUILDING
950 NORTH FIFTH STREET
BATON ROUGE, LA 70802

OR BY TELEPHONE
342-5900, 342-0895, OR 342-0896
1-800-259-5300 OR 1-800-359-5301

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3 and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:87 (January 2000).

§8727. Issuance of Notices

A. Responsibility for the issuance of the notices required by §§8723 and 8725 of this Subchapter may be delegated to the local surplus lines broker responsible for placing the coverage. Notwithstanding the foregoing, the surplus line insurer, upon request of the commissioner, must be able to show that it has procedures in place to assure compliance with this Subchapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3.and R.S. 22:1262.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:87 (January 2000).

Subchapter D. Administrative Actions

§8729. Hearings

A. Hearings, including investigatory hearings, which arise under the provisions of this regulation shall be conducted by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. R.S. 22:1211 et seq., and R.S. 22:1457.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:88 (January 2000).

§8731. Penalties

A. Upon proof of noncompliance with any applicable provisions of this regulation by an insurer, such disciplinary actions and/or penalties as are authorized by law, and in the manner provided thereby, may be imposed by the commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:1211 et seq., and R.S. 22:1457.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:88 (January 2000).

Chapter 89. Regulation 70—Replacement of Life Insurance and Annuities

§8901. Purpose

A. The purpose of this regulation is:

1. to regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities;

2. to protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. It will:

a. assure that purchasers receive information with which a decision can be made in his or her own best interest;

b. reduce the opportunity for misrepresentation and incomplete disclosure; and

c. establish penalties for failure to comply with requirements of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1300 (June 2000).

§8903. Definitions

Direct-Response Solicitation—a solicitation through a sponsoring or endorsing entity or individual solicitation solely through mails, telephone, the internet or other mass communication media.

Electronic Means—relating to sales presentations conducted by a producer utilizing technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities where all signatures are obtained via electronic signature technology.

Existing Contract—an individual annuity contract in force, including a contract that is within an unconditional refund period.

Existing Insurer—the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of *replacement*.

Existing Policy—an individual life insurance policy in force, including a policy under a binding or conditional receipt or a policy that is within an unconditional refund period.

Financed Purchase—the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on a new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender, or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company, within four months before or 13 months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in §8909.A.5 of this regulation.

Illustration—a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in Regulation 55 of the Department of Insurance.

Policy Summary—for the purposes of this regulation, means:

1. for policies or contracts other than universal life policies, a written statement regarding a policy or contract which shall contain, to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan;

2. for universal life policies, a written statement that shall contain at least the following information:

a. the beginning and end date of the current report period;

b. the policy value at the end of the previous report period and at the end of the current report period;

c. the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

d. the current death benefit at the end of the current report period on each life covered by the policy;

e. the net cash surrender value of the policy as of the end of the current report period; and

f. the amount of outstanding loans, if any, as of the end of the current report period.

Producer—for the purposes of this regulation, means agents and brokers.

Registered Contract—a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Replacement—a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

1. lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated; or

2. converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of non-forfeiture benefits or other policy values; or

3. amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid; or

4. reissued with any reduction in cash value; or

5. used in a financed purchase.

Replacing Insurer—the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

Sales Material—a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1300 (June 2000), amended LR 28:1596 (July 2002).

§8905. Exemptions

Editor's Note: The Revised Statute cited in §8905.A.11 has been repealed. The new citation is R.S. 22:1141(C)(2).

A. Unless otherwise specifically included, this regulation shall not apply to transactions involving:

1. credit life insurance;

2. group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single provider in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of §8915;

3. group and/or individual life insurance and annuities used to fund pre-arranged funeral contracts;

4. an application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised, or when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Commissioner of Insurance;

5. proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

6.a. policies or contracts used to fund:

i. an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

ii. a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

iii. a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or

iv. a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

b. notwithstanding Subparagraph 6.a of this Subsection, this regulation shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more annuity providers or policy providers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this Subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement; or, when initiated by an individual employee, assisting with the selection of investment options offered by a single provider in connection with enrolling that individual employee;

7. where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member; or

8. existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed;

9. immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this regulation;

10. structured settlement annuities;

11. any insurer that markets under the Home Service Marketing Distribution System as defined in R.S. 22:1114.M(2)(c).

B. Registered contracts shall be exempt from the requirements of §8911.A.3 and §8913.B with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 644.1 and 1141(C)(2).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1301 (June 2000).

§8907. Duties of Producers

A. A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts.

1. If the applicant indicates that there are no existing policies or contracts, then the producer's duties with respect to replacement are complete.

2. If the applicant indicates that there are existing policies or contracts, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A or other substantially similar form approved by the Commissioner of Insurance; provided, however, no approval shall be required when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud and that it was left with the applicant.

3. Notwithstanding Paragraph A.2 above, when the sales presentation is conducted by electronic means and all signatures are obtained via electronic signature technology, the meaning of "at the time of taking the application" shall be extended to allow for the Producer's submission of electronic information to the company. The requirements of Paragraph A.2 are deemed met when a copy of the required replacement notice electronically signed at the presentation is provided to the applicant within two business days following submission of the case to the company. In no event shall the time for providing the notice exceed five business days from the date the applicant signed the application.

B. The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by the name of the insurer, the insured or annuitant, and the policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, then alternative identification, such as an application or receipt number, shall be listed.

C. In connection with a replacement transaction, the producer shall leave with the applicant the original or a copy of all sales material at the time an application for a new policy or contract is completed. Electronically presented sales material shall be provided to the policyholder in printed form no later than at the time of policy or contract delivery.

D. Except as provided in §8911.C, in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this Section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1301 (June 2000), amended LR 28:1597 (July 2002).

§8909. Duties of Insurers that Use Producers

A. Insurers shall maintain a system of supervision and control to insure compliance with the requirements of this regulation, including at least the following:

1. informing its producers of the requirements of this regulation and incorporate the requirements of this regulation into all relevant producer training manuals prepared by the insurer;

2. providing its producers a written statement of the company's position with respect to the acceptability of replacements and giving guidance to its producers as to the appropriateness of these transactions;

3. a system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Paragraph 2 above;

4. procedures to confirm that the requirements of this regulation have been met; and

5. procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance with this Subsection may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring.

B. Insurers shall have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the Department of Insurance. The capacity to monitor shall include the ability to produce records for each producer's:

1. life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

2. number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

3. annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

4. number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Paragraph A.5 of this Section; and

5. replacements, indexed by replacing producer and existing insurer.

C. Insurers shall:

1. require with or as a part of each application for life insurance or an annuity, a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

2. if there is indication of existing policies or contracts:

a. require with each application for life insurance or an annuity a completed notice regarding replacements as contained in Appendix A;

b. be able to produce completed and signed copies of the notice regarding replacements for at least five years after the termination or expiration of the proposed policy or contract;

c. provide the applicant a hard copy of the required replacement notice within two business days following a producer's submission of case conducted by electronic means. In order to show compliance with §8907.A.2 and 3, the provision must occur no later than five business days from the date of applicant's signing the application.

3. in connection with a replacement transaction, be able to produce copies of any sales material as required by §8907.D, the basic illustration and any supplemental illustrations related to the specific policy or contract which is purchased and the producer's and applicant's signed statements with respect to financing and replacement for at least five years after the termination or expiration of the proposed policy or contract;

4. ascertain that the sales material and illustrations required by §8907.D of this regulation meet the requirements of this regulation and are complete and accurate for the proposed policy or contract; and

5. if an application does not meet the requirements of this regulation, notify the producer and applicant and fulfill the outstanding requirements;

6. records required to be retained by this regulation may be maintained in paper, photograph, microprocess, magnetic, mechanical or electronic media or by any process which accurately reproduces the actual document.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1302 (June 2000), amended LR 28:1597 (July 2002).

§8911. Duties of Replacing Insurers that Use Producers

A. Where a replacement is involved in the transaction, the replacing insurer shall:

1. verify that the required forms are received and are in compliance with this regulation;

2. notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application;

3. mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five business days of a request from an existing insurer;

4. be able to produce copies of the notification regarding replacement required in §8907.B, indexed by producer, for at least five years or until the next regular examination by the insurance department of its state of domicile, whichever is later; and

5. provide to the policy or contract owner notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract; such notice may be included in Appendix A or C.

B. In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, the insurer shall allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

C. If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements of §8907.D, the insurer may:

1. require with each application a statement signed by the producer that:

a. represents that the producer used only company-approved sales material; and

b. states that copies of all sales material were left with the applicant in accordance with §8907.C; and

2. within 10 days of the issuance of the policy or contract:

a. notify the applicant by letter or verbal communication by a person having duties separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with §8907.C;

b. provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

c. stress the importance of retaining copies of the sales material for future reference; and

3. be able to produce a copy of the letter or other verification in the policy file for at least five years after the termination or expiration of the policy or contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1302 (June 2000).

§8913. Duties of the Existing Insurer

A. Where a replacement is involved in the transaction, the existing insurer shall:

1. retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the insurance department of its state of domicile, whichever is later;

2. send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five business days of receipt of the request from the policy or contract owner;

3. upon receipt of a request to borrow, surrender or withdraw any policy values, send to the applicant a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1303 (June 2000).

§8915. Duties of Insurers with Respect to Direct Response Solicitations

A. In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement, as provided in Appendix B, or other substantially similar form approved by the Commissioner of Insurance.

B. If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

1. provide to applicants or prospective applicants, with the policy or contract, a notice as provided in Appendix C, or other substantially similar form approved by the Commissioner of Insurance. In these instances the insurer may delete the references to the producer, including the

producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the Commissioner of Insurance. The insurer's obligation to obtain the applicant's signature shall be satisfied if the insurer can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this Paragraph. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this Section; and

2. comply with the requirements of §8911.A.2 and A.3 if the applicant furnishes the names of the existing insurers, and shall comply with the requirements of §8911.A.4, §8911.A.5 and §8911.B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1303 (June 2000).

§8917. Violations and Penalties

A. Any failure to comply with this regulation shall be considered a violation of R.S. 22:1214. Examples of violations include:

1. any deceptive or misleading information set forth in sales material; or

2. failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement; or

3. the intentional incorrect recording of an answer; or

4. advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

5. advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company;

6. the company's failure to provide the applicant a hard copy of the required replacement notice within two business days following the submission of a case conducted by electronic means. All such provisions must occur no later than five business days from the date of applicant's signing the application.

B. Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the producer's intent to violate this regulation.

C. Where it is determined that the requirements of this regulation have not been met, the replacing insurer shall provide to the policy owner either an in force illustration, if available, or a policy summary for the replacement policy, or available disclosure document for the replacement contract and the appropriate notice regarding replacements in Appendix A or C.

D. Violations of this regulation shall subject the violators to penalties as provided by R.S. 22:1217, 1217.1, and any other applicable provisions of law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner of Insurance, LR 26:1304 (June 2000), amended LR 28:1597 (July 2002).

§8919. Effective Date

A. Except for the provisions contained in §8909, this regulation shall be effective July 1, 2000. The provisions contained in §8909 shall be effective and take effect on January 1, 2001.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1304 (June 2000).

§8921. Appendix A—Replacement Notice

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

(NOTE: This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant).

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

__ Are they affordable?

__ Could they change?

__ You're older—are premiums higher for the proposed new policy?

__ How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

__ New policies usually take longer to build cash values and to pay dividends.

__ Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

__ What surrender charges do the policies have?

__ What expense and sales charges will you pay on the new policy?

__ Does the new policy provide more insurance coverage?

INSURABILITY:

__ If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

__ You may need a medical exam for a new policy.

__ Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

__ Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

__ How are premiums for both policies being paid?

__ How will the premiums on your existing policy be affected?

__ Will a loan be deducted from death benefits?

__ What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

__ Will you pay surrender charges on your old contract?

__ What are the interest rate guarantees for the new contract?

__ Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

__ What are the tax consequences of buying the new policy?

__ Is this a tax free exchange? (See your tax advisor.)

__ Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?

__ Will the existing insurer be willing to modify the old policy?

__ How does the quality and financial stability of the new company compare with your existing company?

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1304 (June 2000), repromulgated LR 26:1482 (July 2000).

§8923. Appendix B—Replacement Notice

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:1305 (June 2000).

§8925. Appendix C—Replacement Notice

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

__ Are they affordable?

__ Could they change?

__ You're older—are premiums higher for the proposed new policy?

__ How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

__ New policies usually take longer to build cash values and to pay dividends.

__ Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

__ What surrender charges do the policies have?

__ What expense and sales charges will you pay on the new policy?

__ Does the new policy provide more insurance coverage?

INSURABILITY:

__ If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

__ You may need a medical exam for a new policy.

__ Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

__ Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

__ How are premiums for both policies being paid?

__ How will the premiums on your existing policy be affected?

__ Will a loan be deducted from death benefits?

__ What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

__ Will you pay surrender charges on your old contract?

__ What are the interest rate guarantees for the new contract?

__ Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

__ What are the tax consequences of buying the new policy?

__ Is this a tax free exchange? (See your tax advisor.)

__ Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?

__ Will the existing insurer be willing to modify the old policy?

__ How does the quality and financial stability of the new company compare with your existing company?

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:644.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner Insurance, LR 26:1305 (June 2000).

Chapter 90. Regulation 72—Commercial Lines Insurance Policy Form Deregulation

§9001. Authority

A. This regulation is adopted pursuant to R.S. 22:620F.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:620.F.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9003. Purpose

A. The purpose of this regulation is to allow for more flexibility in the placement of insurance with large commercial risks within the parameters of the admitted market by establishing an exemption from the form filing, review and approval requirements of the Louisiana Insurance Code, and to adopt the initial definition of an "exempt commercial policyholder". The exemption implemented under this regulation is experimental. It is predicated upon the continued existence of an open and competitive market and the good faith of insurers in carrying out the fiduciary obligations owed to their insureds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:620.F.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9005. Scope and Applicability

A. This regulation applies to all authorized insurers engaged in the business of writing commercial risk property and casualty insurance in this state.

B. This regulation governs the circumstances under which an insurer may issue an insurance policy to a policyholder without first filing the forms with and obtaining approval of the Commissioner of Insurance.

C. The exemption granted by this regulation is limited in scope to certain commercial risk insurance issued to special commercial entities as provided for in §§9011 and 9013 of this regulation, respectively.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3., R.S. 22:620.F.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9007. Severability

A. If any Section or provision of this regulation is held invalid, such invalidity shall not affect other Sections or provisions which can be given effect without the invalid Section or provision, and for this purpose the Sections and provisions of this regulation are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:620.F.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9009. Definitions

A. For the purposes of this regulation the following terms shall have the meaning ascribed herein, unless the context clearly indicates otherwise.

Affiliated Group—two or more persons who are owned or controlled directly or indirectly though one or more intermediaries by, or are under common control with, the person specified (i.e., the named insured) and includes a subsidiary.

Authorized Insurer—shall have the meaning found in R.S.22:5(13).

COI—the Commissioner of Insurance for the state of Louisiana.

Commercial Risk—any kind of risk that is not a personal risk.

Competitive Market—a market in which a reasonable degree of competition exists or which has not been found to be in violation of R.S. 22:1211 et seq. In determining whether a reasonable degree of competition exists within a line of insurance, the COI shall consider the following factors:

a. the number of insurers available to write the coverage;

b. market shares of the leading writers and the changes in market shares over a reasonable period of time;

c. existence of financial or economic barriers that could prevent new firms from entering the market;

d. measures of market concentration and changes of market concentration over time;

e. whether long-term profitability for insurers in the market is reasonable in relation to industries of comparable business risk; and

f. the relationship of insurers' cost to revenue over a reasonable period of time.

Insurer—shall have the meaning found in R.S. 22:5(2).

LDOI—the Louisiana Department of Insurance.

LIRC—the Louisiana Insurance Rating Commission.

Person—an individual, a corporation, a partnership, an association, a trust, a joint stock company, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert.

Personal Risk—homeowners, tenants, private passenger nonfleet automobile, mobile home and other property and casualty insurance for personal, family or household needs.

State—the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:620.F.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9011. Types of Coverage Exempt from Filing and Approval

A. All kinds of commercial property and casualty insurance, including but not limited to Commercial Property, Boiler and Machinery, Commercial Auto, General Liability, Directors and Officers, Business Owners and Inland Marine insurance, written on commercial risks are exempt from the filing and approval provisions of R.S. 22:620 if the policy is issued to an exempt commercial policyholder as defined in §9013 of this regulation, except for the following kinds:

1. worker's compensation and employer's liability insurance;

2. professional liability insurance.

B. The exemption provided for in this Section only applies to policy forms. Rate and rule filings must be made with the LIRC as required by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, R.S. 22:620.F and R.S. 22:1403.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:501 (March 2000).

§9013. Special Commercial Entities

A. *Special Commercial Entity*—a person who meets the criteria for an *exempt commercial policyholder*.

B. An *Exempt Commercial Policyholder*—any person who applies for or procures commercial risk insurance, of the kinds provided for in §9011, and meets the following criteria:

1. has and maintains aggregate annual commercial insurance premiums, excluding worker's compensation and employer's liability, and professional liability insurance premiums, of more than $200,000 in the preceding fiscal year. In determining whether this threshold has been met, premiums paid to one or more insurers are to be added together to reach the total aggregate;

2. at the time the policy is issued the policyholder must have:

a. if a single company not less than 50 employees;

b. if a member of an affiliated group not less than 100 employees collectively;

c. if a municipality a population of not less than 50,000; and

d. if a public entity an operating budget of not less than $20 million for the most recently completed calendar or fiscal year whichever applies;

3. has signed the certification form as provided for in §9015.B of this regulation.

C. Beginning January 1, 2001, the criteria in Subsection B of this Section must be reviewed on an annual basis by the COI for the purposes of determining whether the criteria should be modified. The review must be completed on or before the thirty-first day of March.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:620.F.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:501 (March 2000).

§9015. Disclosure Requirements and Certification Form

A. When soliciting, negotiating or procuring a policy of insurance with an exempt commercial policyholder the agent or broker, or the insurer in cases of direct placement, shall disclose to the policyholder and the policyholder's risk manager, if any, on a form created by the insurer, that a policy form may be used which is exempt from the form filing requirements of the Louisiana Insurance Code.

B. When a policy of insurance is issued or delivered to an exempt commercial policyholder, the insurance agent or broker, or the insurer in cases of direct placement, shall obtain from the policyholder a written certification on the form prescribed below. The certification form must be in not less than 10-point type, and it must be dated and signed by a senior officer or manager of the policyholder and the policyholder's risk manager, if any.

Louisiana Certification of
Exempt Commercial Policyholder Status

Pursuant to Louisiana Regulation 72

The undersigned _____, (the Insured) certifies to _____ (the Insurer) that the Insured meets the criteria below and is an Exempt Commercial Policyholder under Louisiana law. The Insurer may issue a commercial risk insurance policy to an Exempt Commercial Policyholder without filing the policy form with the Louisiana Department of Insurance and the Insurer by signing below certifies that it has the necessary expertise to negotiate its own policy language. The policy must still comply with Louisiana law, and complaints or questions about compliance may be directed to the Louisiana Department of Insurance (1-800-259-5300).

In order to be an Exempt Commercial Policyholder, the Insured must:

1. Execute this Certification Form and return it to the Insurer.
2. Acquire the insurance policy through an insurance agent licensed in Louisiana.
3. Meet the following requirements:

__ Have and maintain aggregate annual commercial risk insurance premiums, excluding workers compensation and employer's liability and professional liability insurance premiums of more than two hundred thousand ($200,000) dollars in the preceding fiscal year. In determining whether this threshold has been met, premiums paid to one or more insurers are to be added together to reach the total aggregate.

__ At the time the policy is issued the policyholder must have (a) if a single company not less than fifty (50) employees; (b) if a member of an affiliated group not less than one hundred (100) employees collectively; (c) if a municipality a population of not less than fifty thousand (50,000); and, (d) if a public entity an operating budget of not less than twenty ($20,000,000) million dollars for the most recently completed calendar or fiscal year whichever applies.

Signed:_____

Date:_____

Printed:_____

Title:_____

Risk Manager:_____

C. The disclosure notice and certification form required by this Section shall be effective for the life of the policy or policies, including renewals, unless the deductible, or policy limits or coverage is significantly modified, in which case a new certification form must be executed.

D. A copy of the certification form shall be maintained by the insurer and by the producing agent or broker in the policyholder's record for a period of five years from the date of issuance of the insurance policy or renewal policy if at renewal a new certification form is executed. The insurer or producing agent or broker shall make such certification forms available for examination by the COI or any person acting on behalf of the COI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3; R.S. 22:620.F; R.S. 22:1211 et seq. and R.S. 22:1301.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:501 (March 2000).

§9017. Requirements for Maintaining Records

A. Any insurer who places insurance with an exempt commercial policyholder, pursuant to this regulation, shall maintain a record on the exempt commercial policyholder. The record shall contain, in addition to the certification form, the following information:

1. any data, statistics, rates, rating plans, rating systems and underwriting rules used in underwriting and issuing such policies;

2. a copy of the policy with date of issuance clearly marked;

3. annual experience data on each risk insured, including but not limited to:

a. written premiums;

b. written premiums at a manual rate;

c. paid losses;

d. outstanding losses;

e. loss adjustment expenses;

f. underwriting expenses;

g. underwriting profits; and

h. profits from contingencies; and

4. a record of all complaints including the date the complaint was made, the name of the complainant, the nature of the complaint and the final resolution.

B. The record required by this Section may be kept in electronic or written form and shall be maintained by the insurer for a period of five years from the date of issuance of the insurance policy or renewal policy if a new certification form is required pursuant to §9015.C. Upon request, the insurer shall produce such record for examination by the COI or any person acting on behalf of the COI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:1211 et seq. and R.S. 22:1301.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

§9019. Exempt Policy Forms

A. Commercial risk property and casualty policy forms which would otherwise have to be filed with and approved by the COI are exempt from this requirement if issued to an exempt commercial policyholder. The exemption of the policy form from the requirement that it be filed with and approved by the COI is not to be taken by an insurer to mean that an insurance contract confected by the use of such a policy form, or policy forms, may in any manner be inconsistent with the statutory law of this state or public policy as expressed by the courts of this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. and R.S. 22:620, and 22:1211 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

§9021. Penalties for Failure to Comply

A. The exemption created by this regulation is a limited one and insurers must strictly comply with the conditions creating the exemption. Failure to comply with the regulation by any person subject to its provisions, after proper notice and a hearing held by the COI, may result in the imposition of such penalties as are authorized by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:620; R.S. 22:1211 et seq., R.S. 22:1115 and R.S. 22:1457.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

Chapter 91. Regulation 68—Patient Rights under Health Insurance Coverage in Louisiana

§9101. Purpose

A. The purpose of this regulation is to clarify the rights of insureds and requirements for health insurance coverage approved under Title 22 of the Louisiana Revised Statutes of 1950. Title 22 of the Louisiana Revised Statutes of 1950 establishes the statutory requirements that health insurance coverage must meet to be issued for delivery in Louisiana. The statutory requirements also establish the intent of the legislature to afford patients with health insurance coverage, basic rights to access covered benefits without undue delays or denials based on arbitrary determinations of medical

necessity. The statutory requirements also establish the legislative intent to prohibit the use of a health insurance coverage requirement or procedure that impinges on the ability of the insured patient to receive appropriate medical advice and/or treatment from a health care provider.

B. To carry out the intent of the legislature and assure full compliance with the provisions of applicable statutory requirements, this regulation sets forth the patient rights under health insurance coverage policies or plans issued for delivery in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:324 (February 2000).

§9103. Definitions

Emergency Medical Condition—the sudden and, unexpected onset of a health condition that requires immediate medical attention, where failure to provide such medical attention could reasonably be expected to result in death, permanent disability, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or could place the person's health in serious jeopardy.

Formal Managed Care Plan—basic health coverage provided by a Health Maintenance Organization licensed to operate in Louisiana. The term does not include health insurance coverage that does not meet the same quality standards that are applied to Health Maintenance Organizations. The term does not apply to any health insurance coverage or employer benefit plan that advertises or markets coverage as "managed care" but is not required to comply with the statutory consumer protections required of formal managed care plans operated by Health Maintenance Organizations in Louisiana.

Geographic Area—a parish.

Health Care Professional—a physician duly licensed to practice medicine by the Louisiana State Board of Medical Examiners, or other health care professional duly licensed, certified, or registered as appropriate in Louisiana, or an acute care hospital licensed to provide medical care in this state.

Health Insurance Coverage—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. This term shall not mean limited benefit insurance as defined in R.S. 22:6(2)(b)(i) or any short term health insurance exempt from guaranteed renewal by PL 102-191, the Health Insurance Portability and Accountability Act of 1996.

Incentive Arrangement—any payment or contractual obligation included in a general payment plan, capitation contract, shared risk arrangement, or other agreement between a managed care organization and a health care provider that is tied to utilization of covered benefits.

Managed Care Plan—has the same meaning as set forth under R.S. 22:215.18A(3) and (4). This includes health insurance policies and health maintenance organization coverage. The term does not include supplemental insurance or limited benefit coverage for out of pocket expenses that is exempt from being classified as creditable coverage under Part of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

Service Area—the geographic area or areas of the state served by a managed care plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:324 (February 2000).

§9105. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all health insurance coverage issued for delivery in the state of Louisiana that is otherwise subject to the statutory requirements of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:324 (February 2000).

§9107. Patient Rights under Policies or Plans of Health Insurance Coverage

A. Prohibition on the Use of Gag Clauses—Applies to HMO Coverage. Patients have a right to talk freely with health care professionals about their health, medical conditions, and any treatment options that are available, including those not covered by their health plan. R.S. 22:215.18(B) prohibits a managed care plan from adopting any requirement that interferes with the ability of a health care professional to communicate with a patient regarding his or her health care. This statutory protection also includes communications regarding treatment options and medical alternatives, or other coverage arrangements. The managed care plan is only allowed to prohibit a health care professional from soliciting alternative coverage arrangements for the purpose of securing financial gain by the health care professional.

B. Prohibition on Incentives to Restrict, Delay or Deny Medically Necessary Care—Applies to HMO and Major Medical Insurance Coverage. Patients have a right to receive medically necessary and appropriate services covered under a managed care plan. R.S. 22:215.19 prohibits managed care plans from offering any financial incentives to health care professionals to deny, reduce, limit, or delay specific, medically necessary, and appropriate services.

C. Holding Managed Care Plans Liable for their Actions, Omissions, or Activities—Applies to HMO and Major Medical Insurance Coverage. Managed care plans are responsible for their actions, activities or omissions that result in harm to the patient. R.S. 22:215.18(G) prohibits

managed care plans from transferring their liability related to activities, actions or omissions of the plan to a health care professional treating the insured. This right does not relieve health care professionals of their responsibilities to appropriately practice within the scope of license, certification, or registration.

D. Guaranteed Direct Access to Obstetricians/ Gynecologists—Applies to HMO and Major Medical Insurance Coverage. Women have a right to see an Obstetrician or Gynecologist for routine care. R.S. 22:215.17 requires health insurance coverage to include direct access to these health care professionals without prior authorization. In addition, health insurance coverage is required to include up to two annual routine visits and follow up treatment within 60 days of either visit if a related condition is diagnosed or treated during the visits. This requirement also applies to pregnancy related care if covered by the policy or plan.

E. Requirement for Appropriate Access to Covered Medical Services—Applies to HMO Coverage

1. Formal managed care plans operated by health maintenance organizations are required to maintain an adequate number of health care professionals to serve plan participants. Covered services must be provided within a reasonable period of time once ordered or prescribed. R.S. 22:2004, 2005, 2013, 2016, and 2021 establish requirements for HMO plans to document that their networks of primary care physicians and specialists are adequate. HMOs are allowed to use point of service options to expand networks and assure access to plan participants.

2. Other health insurance coverage is only allowed to offer managed care as a coverage option. These plans must offer traditional payment of medical claims based on the terms of the policy for deductibles and co-insurance.

F. Confidentiality of Medical Records—Applies to HMO Coverage

1. 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 formal managed care plan shall be held in confidence and shall not be disclosed to any person except:

a. to the extent that it may be necessary to carry out the purposes of operating a formal managed care plan as permitted by law;

b. upon the express consent of the enrollee or potential enrollee;

c. pursuant to statute or court order for the production of evidence or the discovery thereof;

d. in the event of a claim or litigation between such person and the formal managed care plan wherein such data or information is pertinent.

2. A formal managed care plan shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the formal managed care plan is entitled.

G. Prohibit Unreasonable Denial of Emergency Care—Applies to HMO and Major Medical Insurance Coverage

1. Any managed care plan that includes emergency medical services shall provide coverage and shall subsequently pay health care professionals for emergency medical services provided to a covered patient who presents himself/herself with an emergency medical condition.

2. No health insurance plan shall retrospectively deny or reduce payment to health care professionals for emergency medical services of a covered 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:

a. material misrepresentation, fraud, omission, or clerical error;

b. any payment reductions due to applicable co-payments, co-insurance, or deductibles that may be the responsibility of the covered patient;

c. cases in which the covered patient does not meet the emergency medical condition definition, unless the covered patient has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the health insurance plan.

H. Appeal/Grievance Procedures for Denials of Coverage—Applies to HMO and Major Medical Insurance Coverage

1. Formal managed care plans operated by health maintenance organizations are required to have an administrative appeal or grievance process for patients. R.S. 22:2022 requires these plans to submit their appeal/grievance procedures to the Department of Insurance to verify the process or procedures used are reasonable and meet the intent of the statute.

2. In addition, where any insured patient is denied benefits under a health insurance coverage plan, a request can be made to the Department of Insurance for investigation of the denial. Where the denial is valid, the insured is so notified. Where the denial is erroneous, the health insurance coverage plan is required to institute corrective action and may be subject to fines and penalties if a statutory violation has occurred.

I. Guaranteed Continuation of Group Insurance—Applies to HMO and Major Medical Insurance Coverage

1. R.S. 22:215.13 guarantees Louisiana residents who lose their eligibility for coverage under a group health insurance policy or plan, the right to maintain such coverage in force for up to 12 months. This guaranteed continuation of group health insurance does not include accident only coverage, specific disease coverage, limited benefit coverage for dental, vision care or any benefits provided in addition to the basic hospital, surgical, or major medical benefits of the policy. This means that additional or optional insurance coverage purchased is not guaranteed to be provided during

this 12-month continuation period. This continuation of group coverage right is guaranteed for up to one year so long as the following conditions are met:

a. the individual is not eligible for any other group health coverage plan or government sponsored health plan, such as Medicare and Medicaid;

b. the individual timely pays the full monthly premium to keep coverage in force;

c. the individual was not terminated from coverage for fraud or failure to pay any required contribution for the group insurance, and continues to meet the group policy's terms and conditions other than membership in that original group;

d. all dependents covered under the group policy or plan continue to be covered;

e. the group policy has not been terminated or the employer has withdrawn participation in a multiple employer group policy; and

f. the individual continues to reside within the service area of the plan in the event that such group coverage is provided by a Health Maintenance Organization.

2. This right is not automatic and requires the employee or member who is losing coverage to make a written election of continuation on a form furnished by the group policyholder and pay for the first month's coverage prior to the date that coverage is being terminated. Written notification of termination must be provided to the individual in advance to allow election of this right.

3. Special continuation rights are provided to a surviving spouse of an individual who was covered by a group health insurance policy or plan at the time of death and is age 55 or older. Under Louisiana law the surviving spouse is guaranteed the right to continue such group coverage in effect until eligible for any other group coverage. The surviving spouse is also allowed to provide coverage to all dependents that were covered under the deceased spouse's policy or plan at the time of death so long as they remain eligible under the policy.

J. Guaranteed Renewal of Health Insurance Coverage—Applies to HMO and Major Medical Insurance Coverage

1. Under Louisiana law, once health insurance coverage has been purchased, the insurer cannot cancel the coverage unless one of the following conditions exists:

a. failure to pay premiums or contributions in accordance with the terms of the policy;

b. failure to comply with a material plan provision relating to employer contribution or group participation rules;

c. performance of an act or practice that constitutes fraud or the intentional misrepresentation of a material fact under the terms of coverage;

d. the policyholder no longer resides, lives, or works in the service area in the event the coverage is provided under a formal managed care plan operated by a Health Maintenance Organization;

e. the policyholder's coverage is purchased through a bona-fide association plan and the policyholder is no longer eligible to participate in such association;

f. the insurance company is no longer offering the type of coverage purchased and offers to replace the policy with any other type of similar coverage being marketed within 90 days of renewal; or

g. the insurance company is leaving the market and will no longer be selling any group and/or individual health insurance products in Louisiana for a period of at least five years. In such instances the insurer must give each policyholder 180 days advance notice in writing before the policy is terminated. All termination notices must be filed and approved by the Department of Insurance prior to issuance.

K. Limits on Preexisting Medical Condition Exclusions from Coverage—Applies to HMO and Major Medical Insurance Coverage. Under Louisiana law, a health insurance plan is allowed to exclude medical conditions from coverage for a limited period of time. All policies now being sold are prohibited from excluding coverage for preexisting medical conditions for more than 12 months. Regardless of the type of coverage (group or individual), health plans are not allowed to apply an exclusion of coverage based on a preexisting medical condition for more than 12 months.

1. Group Coverage. The medical conditions that can be excluded from coverage are limited to those that were diagnosed or treated during the six month period prior to the day coverage begins under the policy. Any condition that was not being treated during the prior six months cannot be excluded from coverage.

2. Individual Coverage. The medical conditions that can be excluded from coverage are limited to those that were diagnosed, treated or reasonably should have been treated during the 12 month period prior to the day coverage begins under the policy. Any condition that was not diagnosed, treated, or reasonably should have been treated during the prior 12 months cannot be excluded from coverage.

L. Guaranteed Portability Protections—Applies to HMO and Major Medical Insurance Coverage

1. Individuals who are moving their health coverage from one employment situation to another or from one group plan to another are guaranteed the following rights provided they have enrolled in the new plan within 63 days of termination from the prior plan:

a. if the new plan imposes a 12-month preexisting exclusionary period, the individual must be given one month's credit for each month of continuous coverage under the prior plan. If the individual had 12 or more months of continuous coverage under the prior plan, the preexisting

exclusionary period has been satisfied. If the individual had six months of continuous coverage under the prior plan, the preexisting exclusionary period is reduced by six months;

b. if the new employer imposes an exclusionary or waiting period for employees before coverage can begin, such periods do not count as a break in coverage for applying portability rights;

c. during any exclusionary or waiting period, no premiums can be charged to the individual;

d. during any exclusionary or waiting period the individual may maintain their prior coverage if eligible under state continuation of coverage rights, federal COBRA rights, or through purchase of an individual policy;

e. individuals, who had at least 18 months of prior coverage under a group plan, have exhausted or are not eligible for state continuation rights or COBRA rights, are guaranteed access to individual health insurance coverage through the Louisiana Health Insurance Association.

2. Any Louisiana resident who has individual health insurance coverage is guaranteed credit for prior individual coverage when replacing coverage if the insurance plan is applying the prior insurance policy's lifetime benefit usage against the replacement policy. Residents can waive credit for prior coverage to avoid any reduction in the lifetime benefit limit of the replacement coverage. However, state law no longer allows the sale of any policy of insurance that excludes coverage in excess of 18 months.

M. Prohibiting Discrimination against Individuals Based on Health Status—Applies to HMO and Major Medical Insurance Coverage

1. State and federal law prohibit any group health coverage plan from discriminating against individuals based on their health status. This means that an individual's medical status cannot be used to determine eligibility to join a group health plan with certain exceptions. Plans are specifically prohibited from adopting any rules for eligibility or continued eligibility based on any of the following health status related factors:

a. health status;

b. medical condition, including both physical and mental illness;

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; and

h. disability.

2. A plan's rules for eligibility to enroll under a plan also include rules defining any applicable waiting periods for such enrollment. This means that the plan may only apply exclusionary or waiting period uniformly based on date of hire for all eligible employees. No exclusionary or waiting periods are allowed after coverage begins and premiums are being collected from the insured.

N. Prohibition on Use of Prenatal and Genetic Tests by Health Insurance Plans—Applies to HMO and Major Medical Insurance Coverage. State law prohibits health insurance plans from requiring any individual to take genetic tests or prenatal tests prior to being offered coverage. Plans are also prohibited from requesting release of any genetic or prenatal test results or using such information in the determination of benefits or rates for an insured.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:325 (February 2000).

§9109. Patient Responsibilities

A. Under Louisiana law, formal managed care plans operated by health maintenance organizations are held to a higher standard than other health insurance coverage plans that include managed care options. All materials provided by a health insurance coverage plan should be carefully reviewed prior to making a purchasing decision. Managed care requirements under each health insurance coverage plan may vary significantly. For this reason, all patient requirements should be carefully reviewed to assure there is no misunderstanding regarding how medical coverage will be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:327 (February 2000).

Chapter 93. Regulation 80—Commercial Lines Insurance Rate Deregulation

§9301. Authority

A. This regulation is adopted pursuant to R.S. 22:3 and R.S. 22:1401.1(D).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9303. Purpose

A. The purpose of this regulation is to implement the provision of Acts 2004, No. 878 of the Louisiana Legislature, Regular Session, which exempts commercial property and casualty insurers from the rate approval process unless the commissioner determines that the market for a line of insurance is noncompetitive. The regulation specifies the criteria the commissioner will use to determine if there exists a competitive or noncompetitive market.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9305. Scope and Applicability

A. This regulation applies to all authorized insurers engaged in the business of writing commercial property and casualty insurance in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner LR 30:2834 (December 2004).

§9307. Severability

A. If any Section or provision of this regulation is held invalid, such invalidity shall not affect other sections of provisions which can be given effect without the invalid Section or provision, and for this purpose the Sections and provisions of this regulation are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9309. Definitions

A. For the purposes of this regulation the following terms shall have the meaning ascribed herein unless the context clearly indicates otherwise.

Affiliated Group—two or more persons who are owned or controlled directly or indirectly through one or more intermediaries by, or are under common control with, the person specified (i.e., the named insured) and includes a subsidiary.

Anticompetitive Behavior—an insurer monopolizing or attempting to monopolize, or combine with or conspire with any person to monopolize, in any territory, the business of insurance of any kind, subdivision or class.

Authorized Insurer—shall have the meaning found in R.S. 22:5(3).

COI—the Commissioner of Insurance for the state of Louisiana.

Commercial Risk—any kind of risk that is not a personal risk.

Exempt Commercial Policyholder—a person who has and maintains an annual commercial insurance policy premium, excluding workers compensation and, if applicable, medical malpractice liability insurance premiums, of at least $10,000 in the preceding fiscal year.

Insurer—shall have the meaning found in R.S. 22:5(10).

LDOI—the Louisiana Department of Insurance.

Line of Insurance—the lines of business included on the Exhibit of Premiums and Losses (Statutory Page 14) of the Annual Statement Blank.

Noncompetitive Market—a market in which a reasonable degree of competition for a line of insurance does not exist as specified in §9315; or a market which has been found to exhibit anticompetitive behavior or otherwise be in violation of R.S. 22:1211 et seq.

Office of Property and Casualty—the office created by R.S. 36:688.

Person—an individual, a corporation, a partnership, an association, a trust, a joint stock company, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert.

Personal Risk—homeowners, tenants, private passenger nonfleet automobile, mobile home and other property and casualty insurance for personal, family or household needs.

State—the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9311. Types of Insurance Exempt from Rate Filing and Approval Process

A. All lines of commercial property and casualty insurance, including but not limited to Commercial Property, Boiler and Machinery, Fire and Allied Lines, Commercial Auto, General Liability, Non-Medical Professional Liability, Business Owners and Inland Marine insurance, written on commercial risks are exempt from the filing and approval provisions of R.S. 22:1401 et seq., if the policy is issued to an exempt commercial policyholder as defined in §9309, except for the following kinds:

1. workers compensation; and
2. medical malpractice liability insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004).

§9313. Exempt Rates

A. If, after holding a public hearing, the commissioner has declared the market for a line of insurance competitive, then the rates employed for that line are exempt from the filing and approval process. Any such public hearing shall comply with the open meetings law.

B. Exempt rates shall be used only when writing coverage on an exempt commercial policyholder. If exempt rates are used, an informational filing must be submitted to the Office of Property and Casualty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004).

§9315. Noncompetitive Market; Public Notice and Hearing

A. If the commissioner has reason to believe that a noncompetitive market for a line of insurance exists he shall give public notice in the manner specified in R.S. 22:1354(C) and conduct a public hearing.

B.1 In determining whether a reasonable degree of competition does not exist within a line of insurance, the COI shall consider the following factors:

a. the number of insurers available to write the coverage;

b. market shares of the leading writers and the changes in market shares over a reasonable period of time;

c. existence of financial or economic barriers that could prevent new firms from entering the market;

d. measures of market concentration and changes of market concentration over time;

e. whether long-term profitability for insurers in the market is reasonable in relation to industries of comparable business risk;

f. the relationship of insurers' cost to revenue over a reasonable period of time;

g. the availability of insurance coverage to consumers in the markets by specific geographical area, by line of insurance and by class of risk;

h. the extent to which any insurer or group of affiliated insurers controls all or a portion of the market; and

i. the opportunities available to consumers in the market to acquire pricing and other consumer information.

2. These factors must indicate that there is a competitive market in order for a determination to be made that the market is competitive for the line of business under review. If it is determined that a line of business is noncompetitive, the rates for that line of business shall be governed by the file and use provisions of R.S. 1401.1(B) until such time as a finding is made that the market is no longer noncompetitive.

C. The commissioner shall hold an investigatory hearing to determine if the market is noncompetitive if he receives a written request from an aggrieved policyholder or any other affected person or organization. The request must specify the grounds relied upon by the complainant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004).

§9317. Disciplinary Hearings; Fines

A. If the commissioner has reason to believe that an insurer is engaging in anticompetive behavior he may hold a hearing pursuant to an Order to Show Cause, ordering the insurer to appear and show cause why it should not be sanctioned. In making a determination as to whether an insurer is engaging in anticompetitive behavior, the commissioner may consider the factors listed in §9315.

B. The commissioner may hold a disciplinary hearing if he has reason to believe that an insurer is using exempt rates with a policyholder who does not qualify as exempt commercial policyholders.

C. If the commissioner finds that an insurer has violated or otherwise failed to comply with the provisions of this regulation he may impose such fines as are authorized by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004.

§9319. Effective Date

A. This regulation shall take effect on January 1, 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2836 (December 2004).

Chapter 95. Regulation 81—Military Personnel Automobile Liability Insurance Premium Discount and Insurer Premium Tax Credit Program

§9501. Authority

A. This regulation is adopted pursuant to R.S. 22:3 and 22:1425.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:673 (March 2005).

§9503. Purpose

A. The purpose of this regulation is to implement the provisions of Acts 2004, No. 770 of the Louisiana Legislature, Regular Session, as well as to implement the amendment thereto as set forth in Acts 2005, No. 408 of the Louisiana Legislature, Regular Session. The original law created an insurance premium discount program for active military personnel based in Louisiana. The amendment creates a program whereby an insurer is entitled to a tax credit against the premium taxes imposed under R.S. 22:1061 and 1065 for the amount of the military discount provided to qualified active military personnel for the liability portion of their personal automobile liability policy. Both laws require the commissioner to adopt a regulation to implement the military discount program and to develop procedures for the insurer to follow to claim a tax credit and for other related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:673 (March 20, 2005), amended LR 32:94 (January 2006).

§9505. Scope and Applicability

A. This regulation applies to all motor vehicle insurers authorized to engage in the business of writing personal automobile liability insurance in this state. It is also applicable to any personal automobile liability insurance policy purchased in this state from an authorized insurer by active military personnel based in Louisiana to cover personal motor vehicles owned and/or insured by such active military personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:673 (March 20, 2005), amended LR 32:94 (January 2006).

§9507. Severability

A. If any Section or provision of this regulation is held invalid, such invalidity shall not affect other Sections of provisions which can be given effect without the invalid Section or provision. For this purpose the Sections and provisions of this regulation are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:673 (March 2005).

§9509. Definitions

A. For the purposes of this regulation the following terms shall have the meaning ascribed herein unless the context clearly indicates otherwise.

1. *Active Military Personnel*—

a. a single or married person who is based in this state and serving on full time active duty status in the military as a member of:

i. the Army, Navy, Marine Corps or Air Force; or

ii. the Reserve or National Guard; or

iii. the Coast Guard.

b. *Active military personnel* who are deployed out-of-state or overseas whose spouse and dependents remain in this state shall be considered as based in this state for purposes of receiving the discount provided by R.S. 22:1425 and §9515 of this regulation.

AMP—active military personnel.

Authorized Insurer—shall have the meaning found in R.S. 22:5(3).

Automobile Liability Insurance Policy—a policy of insurance acquired in this state, insuring personal motor vehicles of the types described in R.S. 22:636.1.A.(1)(a)-(b), with the exception that for the purposes of this regulation, it shall also include coverage for motorcycles, which provides coverage for bodily injury and property damage liability, medical payments and uninsured motorists coverage as provided in R.S. 22:636.1.A.(2). It includes a renewal policy if, at the time of the renewal, the named insured retains the status of *active military personnel* as defined above. Golf carts, go-carts, off-road vehicles, all-terrain vehicles and other similar motorized vehicles are not motor vehicles for the purposes of R.S. 22:636.1.A.(1)(a)-(b).

Commissioner—the Commissioner of Insurance for the state of Louisiana.

Direct Written Premium—the premium charged by the insurer as consideration for automobile liability insurance coverage.

Insured—the individual who qualifies as *active military personnel*. The spouse and/or any dependents who are under the age of 18 or unmarried full time students under the age of 24 who are insured under the same policy as the *active military personnel* are also included in this definition.

Insurer—shall have the meaning found in R.S. 22:5(10).

LDOI—the Louisiana Department of Insurance.

Named Insured—the person identified as such on the policy.

State—the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:673 (March 2005), amended LR 32:94 (January 2006).

§9511. Premium Discount; Proof of Eligibility

A. On or after July 1, 2005, all authorized insurers shall grant a discount equal to 12.5 percent of the premium charged for an automobile liability insurance policy insuring a vehicle owned by an insured. The discount applies to new and renewal business effective July 1, 2005. The discount applied to new and renewal business effective July 1, 2006, shall be equal to 25 percent of the premium. For interim policy changes the discount mandated by this Subsection shall be applied on a pro-rata basis in the same manner as similar discount programs, such as good-student discounts, are applied by the insurer.

B. The initial obligation to demonstrate eligibility for the premium discount rests with the applicant/AMP. Thus, prior to the insurer applying the premium discount mandated by R.S. 22:1425.A, the applicant/AMP shall provide to the insurer a properly executed Louisiana Application for Military Discount on the current form approved by the Louisiana Department of Insurance (LDOI).

C. An insurer who obtains from an applicant/AMP a properly executed Louisiana Application for Military Discount shall be eligible for a rebuttable presumption that the insurer is entitled to claim a tax credit against the premium taxes levied pursuant to R.S. 22:1061 and 1065.

D. An insurer shall be barred from claiming the benefit of the rebuttable presumption if the insurer knew or should have known that the applicant/AMP provided false or fraudulent information on the Louisiana Application for Military Discount and/or the insurer fails, neglects or refuses to report said false or fraudulent information regarding the applicant/AMP to the LDOI.

E. The initial Louisiana Application for Military Discount shall be properly executed by the applicant/AMP and shall be attested to by the AMP's unit commander or the military officer authorized to administer oaths to the AMP and delivered to the insurer. The insurer is required to maintain the original and all subsequent renewals on file for inspection, verification and audit by the LDOI to ensure that the applicant/AMP is entitled to the premium discount mandated by R.S. 22:1425.A.

F. Active military personnel who is deployed out-of-state or overseas and who is:

1. single, shall be considered as based in this state for purposes of receiving the discount provided by R.S. 22:1425 and §9515 of this regulation; or

2. married, and has a spouse and dependents who remain in this state, shall be considered as based in this state for purposes of receiving the discount provided by R.S. 22:1425 and §9515 of this regulation; or

3. is single, and who has dependents who remain in this state, shall be considered as based in this state for purposes of receiving the discount provided by R.S. 22:1425 and §9515 of this regulation.

G. If single or married AMP are deployed out-of-state or overseas, the insurer is authorized to accept the Louisiana Application for Military Discount if it is properly filled out by any one of the persons who is in a filial relationship to the AMP, to wit: spouse, mother, or father, or any brother, sister, aunt or uncle who has attained the age of majority. The Louisiana Application for Military Discount must still be attested to by the AMP's unit commander or the military officer authorized to administer oaths to AMP.

H. Although it is the obligation of the applicant/AMP to demonstrate eligibility for the premium discount, the insurer has the obligation to act with due diligence with regard to the premium discount program. In furtherance of this due diligence obligation, the insurer may request additional documentation or proof from an applicant/AMP to determine initial or continuing eligibility for the discount if the insurer has a legitimate concern with regard to the authenticity or accuracy of any of the information provided by the applicant/AMP.

I. At each renewal AMP shall be required to re-execute the Louisiana Application for Military Discount in all respects as required by Regulation 81.

J. The Louisiana Application for Military Discount that must be properly executed by the applicant and/or AMP is set forth in §9519, Louisiana Application for Military Discount—Appendix, of this regulation and is incorporated herein as if set forth herein *in extenso*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:673 (March 2005), amended LR 32:94 (January 2006).

§9513. Requests for Tax Credit; Documentation; Dispute Resolution

A. The tax credit authorized by R.S. 22:1425(A), as amended, will be requested by the eligible insurer on an annual calendar year basis. The tax credit will be calculated based upon direct written premium. An insurer is eligible to receive a tax credit against the premium tax levied pursuant to R.S. 22:1061 and 1065 if it is an authorized insurer and the insurer makes a timely request for the tax credit.

B. Insurers seeking a tax credit shall submit a request for premium tax credit to the LDOI in accordance with the reporting schedule for premium taxes levied pursuant to R.S. 22:1061 and 1065 as set forth in the reporting form(s) designed by the commissioner. Insurers shall submit the information required to be maintained by §9515.B of this regulation. A premium tax filing with the tax credit authorized hereunder that does not include the proof required by this regulation will be considered untimely.

C. If the commissioner approves the premium tax filing as being both timely filed and containing all proof required by this regulation, there shall be a rebuttal presumption in favor of the insurer that the insurer is entitled to the tax credit against the premium taxes levied pursuant to R.S. 22:1061 and 1065.

D. The commissioner may disapprove a tax credit either in whole to the extent that the entire premium tax filing is defective, untimely or improperly documented, or in part to the extent that one portion of the premium tax filing is defective, untimely or improper, but the other portion of the premium tax filing is in compliance with §9513 of this regulation. The commissioner shall use the following criteria with regard to the disapproval, in whole or in part, of a premium tax filing, to wit:

1. the premium tax filing is submitted late, unless the insurer can show good cause for the delay;

2. the premium tax filing is incomplete or required documents are missing;

3. the premium tax filing is excessive because a military discount was given to a person who was not eligible to receive said military discount.

E. As explained above, if the commissioner disapproves, in whole or in part, a tax credit filed by an insurer, he shall give written notice to the insurer, stating the grounds for disapproval. The notice shall be sent to the address shown on the records of the LDOI. An insurer shall have 30 days from the date of the notice to dispute the disapproval by the commissioner. If, within this initial 30 day period the insurer can demonstrate, in writing to the commissioner, good cause for not being able to provide the required documents to dispute the disapproval, the commissioner may grant one 60 day extension to dispute the disapproval by the commissioner. No other extensions shall be granted. Any documents submitted by the insurer in rebuttal to the commissioner's disapproval notice shall be verified as true and accurate by an officer of the insurer.

F. Within 30 days of submission of the verified rebuttal, the commissioner shall enter an order either approving or disapproving, in whole or in part, the request by the insurer for a tax credit against the premium taxes levied pursuant to R.S. 22:1061 and 1065.

1. If the tax credit is approved, in whole or in part, the commissioner shall grant to the insurer the amount of the tax credit so approved by the commissioner.

2. If the tax credit is disapproved in its entirety, the commissioner shall enter an order denying the entirety of the requested tax credit. The commissioner's order of disapproval shall be given, in writing, to the insurer by certified mail, return receipt requested. The insurer shall have 30 days from the date of receipt of the commissioner's order of disapproval to request an adjudicatory hearing as provided for by Part XXIX of Title 22 of the Louisiana Revised Statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:674 (March 2005), amended LR 32:95 (January 2006).

§9515. Recordkeeping; Annual Report

A. Any insurer issuing an automobile liability insurance policy to an individual who qualifies for the military discount program shall maintain the following records:

1. the items obtained in compliance with §9511 of this regulation;

2. a copy of the declarations page for each policy for which a tax credit is sought.

B. The request for the tax credit shall be made on a form(s) designed by the commissioner. The request for the tax credit form shall require, among other things, that the insurer provide the following information to the LDOI with regard to the personal automobile liability insurance coverage issued to an AMP and that this information be provided to the LDOI in either an electronic format as per R.S. 22:2.1 or written format.

1. A detailed listing of all policies for which the tax credit is sought. The listing shall include, at a minimum:

a. the policy number of each policy;

b. the effective date of the policy;

c. the term of the policy;

d. the gross direct written premium prior to application of the military discount;

e. the net direct written premium following application of the military discount; and

f. the dollar value of the military discount applied to the policy.

2. The total number of policies written on active military personnel.

3. The total gross direct written premium prior to application of the military discount.

4. The total net direct written premium following application of the military discount.

5. The total end-of-year tax credit sought relative to the military discount.

C. The insurer shall keep the records required by this section in either electronic or written form and the records shall be maintained by the insurer for a period of five years from the date of issuance of the insurance policy to which the military discount has been applied. Upon request, the insurer shall produce such records for examination or audit by the commissioner or any person acting on behalf of the commissioner. The records required by this section shall be considered confidential and are exempt from the Public Records Act found at R.S. 44:4.

D. The initial tax credit filing made by the insurer shall cover the calendar year ending December 31, 2005 and shall be filed on or before March 1, 2006, and thereafter for each subsequent calendar year ending December 31 and filed on or before March 1 thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:674 (March 20, 2005), amended LR 32:96 (January 2006).

§9517. Overpayments; Collection Proceedings; Fines and Hearings

A. If an insurer is examined or audited by the commissioner and it is determined that the insurer received a tax credit in excess of the amount actually due and owing, then the commissioner shall have authority to order the insurer to refund the overpayment to the commissioner. The commissioner shall promptly notify his staff of his determination and provide his staff with a copy of his order.

B. The commissioner shall have standing to institute legal proceedings to collect the amount of any tax credit overpayment and any such proceedings shall be brought in the Nineteenth Judicial District Court. The commissioner's order shall be prima facie proof of the amount due and owing. If legal proceedings are instituted, the commissioner shall be entitled to an additional 20 percent of the amount of the tax credit overpayment found to be due and owing for the cost of collection.

C. An insurer's failure or refusal to refund a tax credit overpayment shall constitute grounds for the commissioner to suspend the insurer' certificate of authority, or to impose a fine not to exceed 10 percent of the tax credit overpayment or $2,500, whichever is more, or both. The insurer shall have 30 days from the date of receipt of the notice of the commissioner's proposed action to request an adjudicatory hearing as provided for by Part XXIX of Title 22 of the Louisiana Revised Statutes.

D. No insurer shall be allowed to withdraw from the state or have its certificate of authority canceled if it has outstanding tax credit overpayments.

E. Nothing in this regulation shall be construed as a limitation on any powers or duties otherwise vested in the commissioner by operation of law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:675 (March 20, 2005), amended LR 32:96 (January 2006).

§9519. Louisiana Application for Military Discount—Appendix

LOUISIANA APPLICATION FOR MILITARY DISCOUNT

NAME OF INSURANCE COMPANY: _____ **POLICY NO. or APPLICATION NO.:** _____

READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. If you have any questions about this "Louisiana Application for Military Discount" form ask your agent for an explanation or contact the Louisiana Department of Insurance at (800) 259-5300 or (225) 342-5900. You must complete all sections of this "Louisiana Application for Military Discount" form. If a section is not applicable enter "N/A."

Full Name of Active Military Personnel: _____ Date: _____

Date of Birth: _____ Home Phone: _____

Home Address: _____

Name of Spouse: _____ Spouse Date of Birth: _____

Name and Date of Birth of Dependents: _____ _____

_____ _____

Year, Make, Model & VIN of Car(s): _____

_____

_____

Branch of Service: _____ Rank: _____

Name of Unit: _____ Unit Commander: _____

Unit Address: _____ Unit Phone: _____

Order No: _____ Date of Order: _____

Active Duty Station: _____ Military Job: _____

The undersigned hereby certifies that he/she is on active duty and permanently based in Louisiana and qualifies as "active military personnel" ("AMP") as defined by R.S. 22:1425 and Regulation 81, and is eligible for the military discount set forth in R.S. 22:1425 for personal automobile liability insurance policy. The AMP further certifies that the information provided in this "Louisiana Application For Military Discount" form is true and correct and that he/she will promptly notify his/her automobile insurer of any change in the above information. The AMP acknowledges that any false, fraudulent or misleading statement may subject him/her to civil and criminal penalties, including those penalties set forth in R.S. 22:1243, and any applicable provisions of Title 14, the Louisiana Criminal Code.

_____ _____

Signature of Active Military Personnel ("AMP") Signature of Commanding Officer or Military Officer Authorized to Administer Oaths

_____ _____

Print Name of Active Military Personnel Print Name and Title of Commanding Officer or Military Officer Authorized to Administer Oaths

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 32:97 (January 2006).

§9521. Effective Date; Implementation

A. This regulation, as amended, shall take effect on August 8, 2005. Insurers shall take steps to timely implement the military discount program so that it is available for all new and renewal business effective July 1, 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1425.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:675 (March 20, 2005), amended LR 32:98 (January 2006).

Chapter 99. Regulation 76—Privacy of Consumer

Subchapter A. General Provisions

§9901. Authority

A. This regulation is adopted pursuant to R.S. 22:2 which charges the Commissioner of Insurance with the duty to enforce and administer all of the provisions of the Insurance Code, the purpose of which is to regulate the business of insurance in all of its phases in the public interest. Sections 501(b) and 505(a)(6) of the Gramm-Leach-Bliley Act specifically designate the Department of Insurance as the agency to establish the appropriate standards covering any person engaged in providing insurance under state law. R.S. 22:3 grants the Commissioner of Insurance authority to promulgate rules and regulations as are necessary for the implementation of the provisions of Title 22. R.S. 22:3052 specifically refers to the protection of the interests of insurance policyholders in this state with respect to financial institution insurance sales, and R.S. 22:3054 grants the Commissioner of Insurance authority to promulgate rules and regulations as may be necessary to effectuate the provisions of Chapter 6 Financial Institution Sales in Title 22.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054, and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

§9903. Purpose

A. The purpose of this regulation is to govern the treatment of nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation:

1. requires a licensee to provide notice to individuals about its privacy policies and practices;

2. describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

3. provides methods for individuals to prevent a licensee from disclosing that information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054, and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

§9905. Scope and Applicability

A. This regulation applies to:

1. nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

B. Compliance. A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act (PL 102-106) may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act in such other state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

§9907. Rule of Construction

A. The examples in this regulation and the sample clauses in Appendix A of this regulation are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

§9909. Definitions

A. As used in this regulation, unless the context requires otherwise:

Affiliate—any company that controls, is controlled by or is under common control with another company.

Clear and Conspicuous—that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice. Examples:

a. *Reasonably Understandable*—a licensee makes its notice reasonably understandable if it:

i. presents the information in the notice in clear, concise sentences, paragraphs, and sections;

ii. uses short explanatory sentences or bullet lists whenever possible;

iii. uses definite, concrete, everyday words and active voice whenever possible;

iv. avoids multiple negatives;

v. avoids legal and highly technical business terminology whenever possible; and

vi. avoids explanations that are imprecise and readily subject to different interpretations;

b. *Designed to Call Attention*—a licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

i. uses a plain-language heading to call attention to the notice;

ii. uses a typeface and type size that are easy to read;

iii. provides wide margins and ample line spacing;

iv. uses boldface or italics for key words; and

v. in a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars;

c. *Notices on Web Sites*—if a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

i. places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

ii. places a link on a screen that consumers frequently access, such as a page on which transactions are conducted that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

Collect—to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

Commissioner—the Commissioner of Insurance.

Company—any natural person, partnership, corporation, association, business, trust, unincorporated organization, or other form of business enterprise, plural or singular, as the case demands.

Consumer—an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative. Examples:

a. an individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship;

b. an applicant for insurance prior to the inception of insurance coverage is a licensee's consumer;

c. an individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution;

d. an individual is a licensee's consumer if:

i.(a). the individual is a beneficiary of a life insurance policy underwritten by the licensee;

(b). the individual is a claimant under an insurance policy issued by the licensee;

(c). the individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(d). the individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

ii. the licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under §§9929, 9931 and 9933 of this regulation;

e. provided that the licensee provides the initial, annual and revised notices under §§9911, 9913 and 9919 of this regulation to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under §§9929, 9931 and 9933 of this regulation, an individual is not the consumer of the licensee solely because he or she is:

i. a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

ii. covered under a group or blanket insurance policy or group annuity contract issued by the licensee; or

f. in no event shall the individuals, solely by virtue of the status described in Subparagraph e.i through iii above, be deemed to be customers for purposes of this regulation;

g. an individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee;

h. an individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

Consumer Reporting Agency—has the same meaning as in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

Control—

a. ownership, control or power to vote 25 percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

b. control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

c. the power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

Customer—a consumer who has a customer relationship with a licensee.

Customer Relationship—a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes. Examples:

a. a consumer has a continuing relationship with a licensee if:

i. the consumer is a current policyholder of an insurance product issued by or through the licensee; or

ii. the consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee;

b. a consumer does not have a continuing relationship with a licensee if:

i. the consumer applies for insurance but does not purchase the insurance;

ii. the licensee sells the consumer airline travel insurance in an isolated transaction;

iii. the individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

iv. the consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

v. the consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

vi. the customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

vii. the individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

viii. for the purposes of this regulation, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

Financial Institution—for the purposes of this regulation means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)). Financial institution does not include:

a. any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);

b. the Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or

c. institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

Financial Product or Service—any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

a. *Financial Service*—includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

Insurance Product or Service—any product or service that is offered by a licensee pursuant to the insurance laws of this state.

a. *Insurance Service*—includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

Licensee—all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered with the Commissioner of Insurance.

a. Producers include persons required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including, but not limited to agents, brokers, solicitors and surplus lines brokers.

b. A licensee is not subject to the notice and opt out requirements for:

i. nonpublic personal financial information set forth in Subchapters A, B, C; and D of this regulation if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(a). the principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

(b). the licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

c.i. Subject to Clause i, *licensee* shall also include an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to R.S. 22:1248, et seq. of this state's laws.

ii. A surplus lines broker or unauthorized insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in Subchapters A, B, C and D of this regulation provided:

(a). the broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under §9929 of this regulation, except as permitted by §9931 or §9933 of this regulation; and

(b). the broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

Nonaffiliated Third Party—any person except:

a. a licensee's affiliate; or

b. a person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person);

c. nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

Nonpublic Personal Financial Information—

a. personally identifiable financial information; and

b. any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available;

c. nonpublic personal financial information does not include:

i. health information;

ii. publicly available information, except as included on a list described in Paragraph b of this Section; or

iii. any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available;

d. examples of lists:

i. nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers;

ii. nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

Nonpublic Personal Information—nonpublic personal financial information.

Opt Out—

a. any direction by the consumer that the licensee not disclose nonpublic personal financial information about the consumer to a non affiliated third party, other than as permitted by §§9929, 9931,and 9933.

Personally Identifiable Financial Information—any information:

a. a consumer provides to a licensee to obtain an insurance product or service from the licensee;

b. about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

c. the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer;

d. examples:

i. information included. Personally identifiable financial information includes:

(a). information a consumer provides to a licensee on an application to obtain an insurance product or service;

(b). account balance information and payment history;

(c). the fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(d). any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(e). any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(f). any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

(g) information from a consumer report;

ii. information not included. Personally identifiable financial information does not include:

(a). health information;

(b). a list of names and addresses of customers of an entity that is not a financial institution; and

(c). information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

Publicly Available Information—any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

a. federal, state or local government records;

b. widely distributed media; or

c. disclosures to the general public that are required to be made by federal, state or local law;

d. reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

i. that the information is of the type that is available to the general public; and

ii. whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so;

e. examples:

i. government records. Publicly available information in government records includes information in government real estate records and security interest filings;

ii. widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public;

f. reasonable basis:

i. a licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded;

ii. a licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3053, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:548 (April 2001).

Subchapter B. Privacy and Opt Out Notices for Financial Information

§9911. Initial Privacy Notice to Consumers Required

A. Initial Notice Requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

1. Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in Subsection E of this Section; and

2. Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by §§9931 and 9933.

B. When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under Paragraph A.2 of this Section if:

1. the licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by §§9931 and 9933, and the licensee does not have a customer relationship with the consumer; or

2. a notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

C. When the Licensee Establishes a Customer Relationship

1. General Rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

2. Examples of Establishing Customer Relationship. A licensee establishes a customer relationship when the consumer:

a. becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

b. agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

D. Existing Customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of Subsection A of this Section as follows:

1. the licensee may provide a revised policy notice, under §9919, that covers the customer's new insurance product or service; or

2. if the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under Subsection A of this Section.

E. Exceptions to Allow Subsequent Delivery of Notice

1. A licensee may provide the initial notice required by Paragraph A.1 of this Section within a reasonable time after the licensee establishes a customer relationship if:

a. establishing the customer relationship is not at the customer's election; or

b. providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

2. Examples of Exceptions

a. Not at Customer's Election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

b. Substantial Delay of Customer's Transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

c. No Substantial Delay of Customer's Transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

F. Delivery. When a licensee is required to deliver an initial privacy notice by this Section, the licensee shall deliver it according to §9921. If the licensee uses a short-form initial notice for non-customers according to §9915.D, the licensee may deliver its privacy notice according to §9915.D.3.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:551 (April 2001).

§9913. Annual Privacy Notice to Customers Required

A.1. General Rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of 12 consecutive months during which that relationship exists. A licensee may define the 12 consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

2. Example. A licensee provides a notice annually if it defines the 12 consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of Year 1, the licensee shall provide an annual notice to that customer by December 31 of Year 2.

B.1. Termination of Customer Relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

2. Examples

a. A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

b. A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

c. For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

d. A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

C. Delivery. When a licensee is required by this Section to deliver an annual privacy notice, the licensee shall deliver it according to §9921.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:552 (April 2001).

§9915. Information to be Included in Privacy Notices

A. General Rule. The initial, annual and revised privacy notices that a licensee provides under §§9911, 9913 and 9919 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

1. the categories of nonpublic personal financial information that the licensee collects;

2. the categories of nonpublic personal financial information that the licensee discloses;

3. the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under §§9931 and 9933;

4. the categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under §§9931 and 9933;

5. if a licensee discloses nonpublic personal financial information to a nonaffiliated third party under §9929 (and no other exception in §§9931 and 9933 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

6. an explanation of the consumer's right under §9923 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

7. any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

8. the licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

9. any disclosure that the licensee makes under Subsection B of this Section.

B. Description of Parties Subject to Exceptions. If a licensee discloses nonpublic personal financial information as authorized under §§9931 and 9933, the licensee is not required to list those exceptions in the initial or annual privacy notices required by §§9911 and 9913. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

C. Examples

1. Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

a. information from the consumer;

b. information about the consumer's transactions with the licensee or its affiliates;

c. information about the consumer's transactions with nonaffiliated third parties; and

d. information from a consumer reporting agency.

2. Categories of Nonpublic Personal Financial Information a Licensee Discloses

a. A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in Subsection C.1 of this Section, as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

i. information from the consumer, including application information, such as assets and income and identifying information, such as name, address and Social Security number;

ii. transaction information, such as information about balances, payment history and parties to the transaction; and

iii. information from consumer reports, such as a consumer's creditworthiness and credit history.

b. A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

c. If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

3. Categories of Affiliates and Nonaffiliated Third Parties to whom the Licensee Discloses

a. A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

b. Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

c. A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

4. Disclosures under Exception for Service Providers and Joint Marketers. If a licensee discloses nonpublic personal financial information under the exception in §9929 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Paragraph A.5 of this Section if it:

a. lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of Paragraph A2. of this Section, as applicable; and

b. states whether the third party is:

i. a service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

ii. a financial institution with whom the licensee has a joint marketing agreement.

5. Simplified Notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under §§9931 and 9933, the licensee may simply state that fact, in addition to the information it shall provide under Paragraphs A.1, A.8, A.9, and Subsection B of this Section.

6. Confidentiality and Security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

a. describes in general terms who is authorized to have access to the information; and

b. states whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

D. Short-Form Initial Notice with Opt Out Notice for Non-Customers

1. A licensee may satisfy the initial notice requirements in §§9911.A.2 and 9917.C for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in §9917.

2. A short-form initial notice shall:

a. be clear and conspicuous;

b. state that the licensee's privacy notice is available upon request; and

c. explain a reasonable means by which the consumer may obtain that notice.

3. The licensee shall deliver its short-form initial notice according to §9921. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to §9921.

4. Examples of Obtaining Privacy Notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

a. provides a toll-free telephone number that the consumer may call to request the notice; or

b. for a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

E. Future Disclosures. The licensee's notice may include:

1. categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

2. categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

F. Sample Clauses. Sample clauses illustrating some of the notice content required by this Section are included in Appendix A of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:553 (April 2001).

§9917. Form of Opt Out Notice to Consumers and Opt Out Methods

A.1. Form of Opt Out Notice. If a licensee is required to provide an opt out notice under §9923, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that Section. The notice shall state:

a. that the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

b. that the consumer has the right to opt out of that disclosure; and

c. a reasonable means by which the consumer may exercise the opt out right.

2. Examples

a. Adequate Opt Out Notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

i. identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in §9915.A.2 and 3, and states that the consumer can opt out of the disclosure of that information; and

ii. identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

b. Reasonable Opt Out Means. A licensee provides a reasonable means to exercise an opt out right if it:

i. designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

ii. includes a reply form together with the opt out notice;

iii. provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

iv. provides a toll-free telephone number that consumers may call to opt out.

c. Unreasonable Opt Out Means. A licensee does not provide a reasonable means of opting out if:

i. the only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

ii. the only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

d. Specific Opt Out Means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

B. Same Form as Initial Notice Permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with §9911.

C. Initial Notice Required When Opt Out Notice Delivered Subsequent to Initial Notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with §9911, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

D. Joint Relationships

1. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer (as explained in Paragraph 5 of this Subsection).

2. Any of the joint consumers may exercise the right to opt out. The licensee may either:

a. treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

b. permit each joint consumer to opt out separately.

3. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

4. A licensee may not require all joint consumers to opt out before it implements any opt out direction.

5. Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

a. send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary;

b. treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction;

c. permit John and Mary to make different opt out directions. If the licensee does so:

i. it shall permit John and Mary to opt out for each other;

ii. if both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

iii. if John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

E. Time to Comply with Opt Out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

F. Continuing Right to Opt Out. A consumer may exercise the right to opt out at any time.

G. Duration of Consumer's Opt Out Direction.

1. A consumer's direction to opt out under this Section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

2. When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

H. Delivery. When a licensee is required to deliver an opt out notice by this Section, the licensee shall deliver it according to §9921.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:554 (April 2001).

§9919. Revised Privacy Notices

A. General Rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under §9911, unless:

1. the licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

2. the licensee has provided to the consumer a new opt out notice;

3. the licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

4. the consumer does not opt out.

B. Examples

1. Except as otherwise permitted by §§9929, 9931, and 9933, a licensee shall provide a revised notice before it:

a. discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

b. discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

c. discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

2. A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

C. Delivery. When a licensee is required to deliver a revised privacy notice by this Section, the licensee shall deliver it according to §9921.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:555 (April 2001).

§9921. Delivery

A. How to Provide Notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

B.1. Examples of Reasonable Expectation of Actual Notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

a. hand-delivers a printed copy of the notice to the consumer;

b. mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

c. for a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

d. for an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

2. Examples of Unreasonable Expectation of Actual Notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

a. only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

b. sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

C. Annual Notices Only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

1. the customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

2. the customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

D. Oral Description of Notice Insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

E. Retention or Accessibility of Notices for Customers

1. For customers only, a licensee shall provide the initial notice required by §9911.A.1, the annual notice required by §9913.A, and the revised notice required by §9919 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

2. Examples of Retention or Accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

a. hand-delivers a printed copy of the notice to the customer;

b. mails a printed copy of the notice to the last known address of the customer; or

c. makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

F. Joint Notice with Other Financial Institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

G. Joint Relationships. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of §§9911, 9913 and 9919, respectively, by providing one notice to those consumers jointly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:556 (April 2001).

Subchapter C. Limits on Disclosures of Financial Information

§9923. Limits on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties

A.1. Conditions for Disclosure. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

a. the licensee has provided to the consumer an initial notice as required under §9911;

b. the licensee has provided to the consumer an opt out notice as required in §9917;

c. the licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

d. the consumer does not opt out.

2. Examples of Reasonable Opportunity to Opt Out. A licensee provides a consumer with a reasonable opportunity to opt out if:

a. by mail. The licensee mails the notices required in Paragraph 1 of this Subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within 30 days from the date the licensee mailed the notices;

b. by electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in Paragraph 1 of this Subsection electronically, and the licensee allows the customer to opt out by any reasonable means within 30 days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account;

c. isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in Paragraph 1 of this Subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

B. Application of Opt Out to All Consumers and All Nonpublic Personal Financial Information

1. A licensee shall comply with this Section, regardless of whether the licensee and the consumer have established a customer relationship.

2. Unless a licensee complies with this Section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

C. Partial Opt Out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:556 (April 2001).

§9925. Limits on Re-Disclosure and Reuse of Nonpublic Personal Financial Information

A.1. Information the Licensee Receives under an Exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in §§9931 or 9933 of this regulation, the licensee's disclosure and use of that information is limited as follows:

a. the licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

b. the licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

c. the licensee may disclose and use the information pursuant to an exception in §§9931 or 9933 of this regulation, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

2. Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

B.1. Information a Licensee Receives Outside of an Exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in §§9931 or 9933 of this regulation, the licensee may disclose the information only:

a. to the affiliates of the financial institution from which the licensee received the information;

b. to its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

c. to any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

2. Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in §§9931 or 9933:

a. the licensee may use that list for its own purposes; and

b. the licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in §§9931 or 9933, such as to the licensee's attorneys or accountants.

C. Information a Licensee Discloses under an Exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in §§9931 or 9933 of this regulation, the third party may disclose and use that information only as follows:

1. the third party may disclose the information to the licensee's affiliates;

2. the third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

3. the third party may disclose and use the information pursuant to an exception in §§9931 or 9933 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

D. Information a Licensee Discloses Outside of an Exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in §§9931 or 9933 of this regulation, the third party may disclose the information only:

1. to the licensee's affiliates;

2. to the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

3. to any other person, if the disclosure would be lawful if the licensee made it directly to that person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:557 (April 2001).

§9927. Limits on Sharing Account Number Information for Marketing Purposes

A. General Prohibition on Disclosure of Account Numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

B. Exceptions. Subsection A of this Section does not apply if a licensee discloses a policy number or similar form of access number or access code:

1. to the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

2. to a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

3. to a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

C. Examples

1. Policy Number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

2. Policy or Transaction Account. For the purposes of this Section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:557 (April 2001).

Subchapter D. Exceptions to Limits on Disclosures of Financial Information

§9929. Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing

A. General Rule

1. The opt out requirements in §§9917 and 9923 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

a. provides the initial notice in accordance with §9911; and

b. enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in §§9931 or 9933 in the ordinary course of business to carry out those purposes.

2. Example. If a licensee discloses nonpublic personal financial information under this Section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of Subparagraph 1.b of this Subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in §9931 or §9933 in the ordinary course of business to carry out that joint marketing.

B. Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under Subsection A of this Section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

C. Definition of Joint Agreement. For purposes of this Section, *joint agreement* means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:558 (April 2001).

§9931. Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions

A. Exceptions for Processing Transactions at Consumer's Request. The requirements for initial notice in §9911.A.2, the opt out in §§9917 and 9923, and service providers and joint marketing in §9929 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

1. servicing or processing an insurance product or service that a consumer requests or authorizes;

2. maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

3. a proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

4. reinsurance or stop loss or excess loss insurance.

B. *Necessary to Effect, Administer or Enforce a Transaction*—that the disclosure is:

1. required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

2. required, or is a usual, appropriate or acceptable method:

a. to carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

b. to administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

c. to provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

d. to accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

e. to underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

f. in connection with:

i. authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

ii. the transfer of receivables, accounts or interests therein; or

iii. the audit of debit, credit or other payment information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:558 (April 2001).

§9933. Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information

A. Exceptions to Opt Out Requirements. The requirements for initial notice to consumers in §9911A.2, the opt out in §§9917 and 9923, and service providers and joint marketing in §9929 do not apply when a licensee discloses nonpublic personal financial information:

1. with the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

2.a. to protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

b. to protect against or prevent actual or potential fraud or unauthorized transactions;

c. for required institutional risk control or for resolving consumer disputes or inquiries;

d. to persons holding a legal or beneficial interest relating to the consumer; or

e. to persons acting in a fiduciary or representative capacity on behalf of the consumer;

3. to provide information to an insurance rate advisory organizations for the purpose of gathering statistical rate making information, guaranty funds or agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

4. to the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Record keeping), the Commissioner of Insurance, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

5.a. to a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

b. from a consumer report reported by a consumer reporting agency;

6. actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

7.a. to comply with federal, state or local laws, rules and other applicable legal requirements;

b. to comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities;

c. to respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

8. for purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan;

9. for purposes related to:

a. an order of rehabilitation or liquidation pursuant to R.S. 22:731 et seq.;

b. any other provision of law which authorizes the Commissioner of Insurance to take over, rehabilitate, liquidate, or wind up the affairs of a licensee.

B. Example of Revocation of Consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under §9917.F.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:3052, 22:3054 22:731, et seq. and Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:559 (April 2001).

Subchapter E. Additional Provisions

§9945. Protection of Existing Requirements

A. Nothing in this regulation shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) or of Louisiana Revised Statutes Sections 22:1474, 23:1200.3 or 22:3063, and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under Section 603 of the federal Fair Credit Reporting Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:1474, 22:3052, 22:3054, 22:3063, 23:1200.3, Gramm-Leach-Bliley Act, Public Law 106-102–Nov. 12, 1999, 15 U.S.C. 1681, et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:559 (April 2001).

§9947. Nondiscrimination

A. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:1214, 22:2020; 22:3052; 22:3054, 22:3063.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:559 (April 2001).

§9949. Violations and Penalties

A. Any failure to comply with this regulation shall be considered a violation of R.S. 22:1214, et seq.

B. Violations of this regulation shall subject the violators to penalties as provided in R.S. 22:1217, 22:1217.1, and any other applicable provisions of law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, 22:3, 22:1214, et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:559 (April 2001).

§9951. Severability

A. If any provision or item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation which can be given effect without the invalid provision, item, or application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 24:175.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:560 (April 2001).

§9953. Effective Date

A. Effective Date. This regulation is effective November 13, 2000. In order to provide sufficient time for licensees to establish policies and systems to comply with the requirements of this regulation, the commissioner has extended the time for compliance with this regulation until July 1, 2001.

B.1. Notice Requirement for Consumers who are the Licensee's Customers on the Compliance Date. By July 1, 2001, a licensee shall provide an initial notice, as required by Section 5, to consumers who are the licensee's customers on July 1, 2001.

2. Example. A licensee provides an initial notice to consumers who are its customers on July 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

C. Two-Year Grandfathering of Service Agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of §9929.A.1.b of this regulation, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner; LR 27:560 (April 2001).

§9955. Appendix A—Sample Clauses

A. Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1—Categories of Information a Licensee Collects (All Institutions)

A licensee may use this clause, as applicable, to meet the requirement of §9915.A.1 to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

A-2–Categories of Information a Licensee Discloses (Institutions that Disclose Outside of the Exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of §9915.A.2 to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in §§9929, 9931 and 9933.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, Social Security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premiums, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described (describe location in the notice, such as “above” or "below").

A-3–Categories of Information a Licensee Discloses and Parties to whom the Licensee Discloses (Institutions that Do Not Disclose Outside of the Exceptions)

A licensee may use this clause, as applicable, to meet the requirements of §9915.A.2, 3, and 4 to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in §§9931 and 9933.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4–Categories of Parties to whom a Licensee Discloses (Institutions that Disclose outside of the Exceptions)

A licensee may use this clause, as applicable, to meet the requirement of §9915.A.3 to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in §§9929, 9931 and 9933, as well as when permitted by the exceptions in §§9931 and 9933.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as (provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents");
- Non-financial companies, such as (provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"); and
- Others, such as (provide illustrative examples, such as "non-profit organizations").

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5–Service Provider/Joint Marketing Exception

A licensee may use one of these clauses, as applicable, to meet the requirements of §9915.A.5 related to the exception for service providers and joint marketers in §9929. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, Social Security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premium, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described (describe location in the notice, such as "above" or "below") to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6–Explanation of Opt Out Right (Institutions that Disclose outside of the Exceptions)

A licensee may use this clause, as applicable, to meet the requirement of §9915A.6 to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in §§9929, 9931 and 9933.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)"].

A-7–Confidentiality and Security (All Institutions)

A licensee may use this clause, as applicable, to meet the requirement of §9915.A.8 to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to (provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"). We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3 and Gramm-Leach-Bliley Act, Public Law 106-102-Nov. 12, 1999.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 27:560 (April 2001).

Chapter 101. Regulation 78—Policy Form Filing Requirements

§10101. Purpose

A. The purpose of this regulation is:

1. to provide for the uniform and practicable administration of the form filing, review and approval requirements of the Louisiana Insurance Code;

2. to clarify the disparate provisions of R.S. 22:620.B;

3. to further protect the interests of insurance consumers and the public through improvements to the form filing, review and approval processes; and

4. to assist all insurers doing business in the state of Louisiana in complying with the form filing, review and approval requirements of the Louisiana Insurance Code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and *Directive* 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2539 (December 2002).

§10103. Authority

A. This regulation is adopted pursuant to R.S. 22:3.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and Directive 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2539 (December 2002).

§10105. Applicability and Scope; Severability

A. This regulation applies to all insurers doing business in the state of Louisiana subject to the form filing, review and approval provisions of the Louisiana Insurance Code.

B. If any provision of this regulation, or its application to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this regulation which can be given effect without the invalid provision or application, and to that end, the provisions of this regulation are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and Directive 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2539 (December 2002).

§10107. Filing and Review of Health Insurance Policy Forms and Related Matters

A. Definitions. As used in this Section, the following terms shall have the meaning or definition as indicated herein.

Affirmative Approval—department approval, as a result of the department taking action, following compliance review of a complete filing, or a filing pursuant to §4.D hereof.

Association—an organization legally formed for purposes other than the procurement of insurance and, depending upon the particular insurance products in question, meeting the requirements of R.S. 22:215.A(1)(a)(iv), or R.S. 22:215.A(4)(a), or R.S. 22:250.1(5)(b), or R.S. 22:1734(4), whichever is applicable.

Basic Insurance Policy Form—an insurance contractual agreement delineating the terms, provisions and conditions of a particular insurance product. It includes certificates of coverage and any other evidence of coverage, subscriber agreements, application forms where written application is required and is to be attached to the policy or be a part of the contract, and any life or health and accident rider or endorsement form. It does not include policies, riders, or endorsements designed, at the request of the individual policyholder, contract holder, or certificate holder, to delineate insurance coverage 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.

Certification of Compliance—certification by an insurer, executed by an officer or authorized representative of the insurer on a form prescribed by the department, that upon knowledge and belief a filing is complete and in compliance with all applicable statutes, and rules and regulations promulgated by the department. A Certification of Compliance must be included with any filing for certified approval.

Certified Approval—expedited approval by the department of a complete filing based upon the inclusion of a Statement of Compliance and a Certification of Compliance, executed by an officer or authorized representative of the filing insurer on a form prescribed by the department. The department shall by directive determine those specific types of coverages and particular types of contracts for which the certified approval procedure is either required or available at the option of the insurer.

Complete Filing—the filing of a single insurance product, including any required filing fees, a basic insurance policy form, application form and supplemental application form, if any, to be attached to the policy or be a part of the contract, any life or health and accident rider or endorsement forms, all items required under Subsection C hereof, "General Filing Requirements," and any other requirements as may be set forth in the applicable Statement of Compliance.

Compliance Audit—a retrospective review conducted by the department of previously approved basic insurance policy forms to determine compliance with applicable law.

Compliance Review—department review of a filing made pursuant to this Section to determine either that the filing is in compliance with all applicable statutes, rules and regulations, or that the filing should be disapproved for noncompliance.

Deemed Approval—approval of a complete filing based upon notice, as provided herein, made to the department by the filing insurer, following expiration of the specific time periods as provided herein, where affirmative approval has not been granted and the filing has not been disapproved by the department.

Department—the Louisiana Department of Insurance, and includes the Commissioner of Insurance.

Endorsement—a written agreement attached to an insurance product to add or subtract coverage, or otherwise modify the product.

Insurance Product—a basic insurance policy form delineating the terms, provisions and conditions of a specific type of coverage under a particular type of contract.

Insurer—every person engaged in the business of making contracts of insurance, as further defined in R.S. 22:5. As used in this Section, insurer shall also include fraternal benefit societies and health maintenance organizations.

Method of Marketing—marketing either through independent or captive agents; telephone, e-mail or direct mail solicitation; groups, organizations, associations or trusts; and/or the Internet.

Required Filing Fee—the fee assessed per product or filing pursuant to state insurance law.

Rider—an endorsement to an insurance product that modifies clauses and provisions of the product, including adding or excluding coverage.

Statement of Compliance—a form prescribed by the department, detailing the requirements specific to a particular form of coverage and contract type.

Trust—a fund established by an employer, two or more employers in the same industry, a labor union, or an association, pursuant to a trust instrument which transfers title to property and/or funds to one or more trustees to be administered as fiduciaries for the benefit of others, pursuant to R.S. 22:215.A.(1).

B. Filing Required

1. Pursuant to R.S. 22:620.A, no basic insurance policy form, 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 rider or endorsement form, may be issued or delivered in this state unless and until it has been filed with and approved by the Commissioner of Insurance. This requirement also applies to any group health or accident insurance policy covering residents of Louisiana, regardless of where issued or delivered. Every page of each such form, including rider and endorsement forms, filed with the department must be identified by a form number in the lower left corner of the page.

2. A health and accident transmittal document must accompany every filing, describing the items included in the filing, the insurance product for which the filing is being made, and the method of marketing to be used for the product. If the filing will include life insurance to be offered as an optional benefit under the base health insurance contract, the policy forms should be submitted in triplicate, notwithstanding the provisions of Paragraph C.2 hereof, and include the appropriate Statement of Compliance for said life insurance product.

C. General Filing Requirements

1. The department shall designate, by directive, those insurance products which must be filed pursuant to the requirements for certified approval as set forth in Subsection F hereof, "Time Periods and Requirements for Certified Approval of Policy Form Filings." A directive issued pursuant to this Subsection may also designate those insurance products which may, at the discretion of the insurer, be filed either pursuant to said requirements for Certified Approval, or as ordinary filings subject to review as set forth in Subsection E hereof. All insurance products not so designated shall be filed pursuant to the requirements for Compliance Review as set forth in Subsection E hereof, "Time Periods and Requirements for Compliance Review of Basic Insurance Policy Forms."

2. Other than as specified in Subsection D hereof, "Exceptions," only complete filings will be accepted, whether by mail or as otherwise authorized. In order for the department to conduct a proper compliance review or compliance audit of an insurance product, all items associated therewith must be included. A filing will be determined incomplete and will be disapproved if it does not contain all applicable items.

a. All filings of an insurance product must include, in final wording, the following items, in order:

i. required filing fee, per insurance product, per insurance company;

ii. completed Health and Accident Transmittal Document, as prescribed by the department;

iii. Statement of Compliance for said product;

iv. policy forms filed for approval, in duplicate;

v. application form, in duplicate;

vi. rider or endorsement forms, in duplicate;

vii. copies of any sample identification card intended for issue to covered persons, in duplicate;

viii. initial premium rates and classification of risks; and

ix. stamped, self-addressed envelope of sufficient size for use in returning the company's set of the policy forms filed, unless filed electronically.

b. Filings of policy forms for one or more standardized Medicare Supplement insurance plans, or one or more standardized Medicare Select insurance plans, shall be considered a filing of one insurance product per insurer. Such filings must include, in final wording, the following items, in order:

i. required filing fee, per insurance product, per insurance company;

ii. required filing fee for premium rates, rating schedule and supporting documentation; and required filing fee for advertisements;

iii. completed Health and Accident Transmittal Document, as prescribed by the department;

iv. Statement of Compliance for said product;

v. policy forms filed for approval, in duplicate;

vi. outline of coverage, in duplicate;

vii. application form, in duplicate;

viii. replacement notice, in duplicate;

ix. rider or endorsement forms, in duplicate;

x. proposed plan of operation, as set forth in LAC 37:XIII.525.E for Medicare Select insurance plans, in duplicate;

xi. premium rates, rating schedule, and supporting documentation, in duplicate;

xii. any new related advertising as defined in Rule 3A, §4, in duplicate; and

xiii. stamped, self-addressed envelope of sufficient size for use in returning the company's set of the policy forms filed, unless filed electronically.

c. Filings of policy forms for Long Term Care insurance must include, in final wording, the following items, in order:

i. required filing fee, per insurance product, per insurance company;

ii. completed Health and Accident Transmittal document, as prescribed by the department;

iii. Statement of Compliance for said product;

iv. policy forms filed for approval, in duplicate;

v. outline of coverage, in duplicate;

vi. application form, in duplicate;

vii. replacement notice, in duplicate;

viii. rider or endorsement forms, in duplicate;

ix. premium rates and classification of risks;

x. personal worksheet, as per Regulation 46, Appendix B, in duplicate;

xi. disclosure, as per Regulation 46, Appendix C, in duplicate;

xii. suitability letter, as per Regulation 46, Appendix D, in duplicate;

xiii. any new related advertising as defined in Rule 3, 3.4, in duplicate; and

xiv. stamped, self-addressed envelope of sufficient size for use in returning the company's set of the policy forms filed, unless filed electronically.

d. Filings of all group insurance products must include the group master contract, individual certificates or subscriber agreements or other statements of coverage, group application, individual enrollment forms, and any conversion insurance policy and application for conversion, if offered under the group master contract.

e. Filings of group health and accident products intended for issue to an association are limited to associations as defined herein and must include the association's constitution, by-laws, membership application, membership agreement and brochure of membership benefits other than the insurance products offered.

f. Filings of group health and accident products intended for issue to a trust are limited to trusts established by an employer or association and must include the trust agreement, articles of incorporation or other instrument creating the trust, and member adoption agreement. If the trust was established by an association, include the information described in Subparagraph C.2.e hereof.

g. Filings of amendatory riders or endorsements are permitted where the insurance product to be altered was originally certified or granted affirmative approval not more than three years prior to the filing of said amendatory rider or endorsement. Such filings must include specimen copies of the pertinent previously approved or certified forms, the dates previously approved or certified, and the specific terms and provisions being amended, underlined in red or similarly emphasized. Such filings must also include an affidavit, on a form prescribed by the department, affirming that the insurance product, if amended by rider or endorsement as requested, will be fully compliant with all pertinent statutes and regulations. Premium rates and classification of risks are not required with such filings.

h. Filings of amendatory riders or endorsements, as needed to bring into compliance with law any existing insurance products that have been previously certified or granted affirmative approval and are currently in force, but are no longer being marketed, must include specimen copies of the previously approved or certified forms, the dates previously approved or certified, and the specific terms and provisions being amended, underlined in red or similarly emphasized. Premium rates and classification of risks are not required with such filings. The transmittal document should advise that the previously approved or certified form is no longer being marketed.

D. Exceptions. Exceptions to the requirements for a complete filing may be allowed, at the discretion of the department, subject to the conditions stated herein, for the following policy forms.

1. Application forms or enrollment forms to be used with a particular insurance product, or with multiple insurance products, provided that the policy form filings and dates approved are identified for each previously approved product with which the application form or enrollment form will henceforth be used, and the application form or enrollment form is included with any subsequently filed basic insurance policy forms as needed to constitute a complete filing. No filing fees will be required for these filings.

2. Identification Cards. No filing fees will be required for these filings.

3. Medicare Supplement Advertising. Such filings must include statutory filing fees.

4. Long Term Care Advertising. No filing fees will be required for these filings.

5. Medicare Supplement Rate Filings. Such filings must clearly indicate the percentage of increase in rates for each standardized plan and existing pre-standardized plan. Such filings must include statutory filing fees for standardized plans.

6. Exclusionary riders pursuant to R.S. 22:250.11.C; provided that the policy form filings and dates approved are identified for each previously approved product with which the rider form will henceforth be used. No filing fees will be required for these filings. The rider form shall be included with any subsequently filed basic insurance policy forms as needed to constitute a complete filing.

7. Assumption certificates, which must be filed in duplicate, with a single copy of the assumption agreement, letter of domiciliary state approval, information fully identifying the block of business being assumed, the number of covered lives residing in the state of Louisiana to be affected by the assumption, and the effective date of the assumption. No filing fees will be required for these filings.

8. Following approval of a complete filing of a Medicare Supplement insurance product, subsequent filings by the same insurer of standardized plans of insurance of the same type do not require inclusion of associated forms such as the replacement notice or plan of operation, unless changes have been made or the plan of operation has changed.

9. Following approval of a complete filing of a Long Term Care insurance product, subsequent filings by the same insurer of other Long Term Care products do not require inclusion of associated forms such as the replacement notice, personal worksheet, disclosure notice and suitability letter, unless changes have been made.

10. Forms for lines of insurance or insurance products specifically exempted pursuant to statute.

E. Time Periods and Requirements for Compliance Review of Basic Insurance Policy Forms

1. The time periods stated in this Section do not begin until the date a complete filing, or a filing pursuant to Subsection D hereof, "Exceptions," is received by the department.

2. If a filing made is incomplete, notice of disapproval in accordance with R.S. 22:621(6) will be issued for failure to comply with the requirements of this regulation.

3. A basic insurance policy form must be submitted to the department in accordance with the "General Filing Requirements" of this Section no less than 45 days in advance of planned issuance, delivery or use.

4. If affirmatively approved by the department prior to expiration of the 45-day period allowed for department review of a filing, the policy forms filed may be used on or after the date approved.

5. If disapproved, the policy forms filed may not be used.

6. At the expiration of 45 days, if no order has been issued affirmatively approving or disapproving a filing, the insurer may submit written notice to the department that the filing has been deemed approved on a specific date, or advise when the filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

7. The Commissioner of Insurance may send written notice prior to expiration of the initial 45-day period extending the time allowed for approval or disapproval by an additional 15 days.

a. If affirmatively approved by order of the commissioner prior to expiration of the 15-day extended period allowed for department review, the policy forms filed may be used on or after the date approved.

b. At the expiration of the 15-day extended period, if no order has been issued affirmatively approving or disapproving the policy form filing, the insurer may submit written notice to the department that the policy forms filing has been deemed approved on a specific date, or advise when the policy forms filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

F. Time Periods and Requirements for Certified Approval of Policy Form Filings

1. The department will make available Statements of Compliance setting forth the statutory and regulatory requirements specific to the various forms of coverage and contract types, as well as Certification of Compliance forms.

2. A policy form filing submitted for certified approval must include the following documents:

a. Statement of Compliance applicable to the form of coverage and contract type being submitted;

b. signed and dated Certification of Compliance;

c. all other items as set forth in Paragraph C.2 hereof.

3. If the filing is incomplete, notice of disapproval in accordance with R.S. 22:621(6) will be issued for failure to comply with the requirements of this regulation.

4. At the expiration of 15 days from acknowledged receipt of a filing by the department, if no order has been issued affirming certified approval or disapproving the policy form filing, the insurer may submit written notice to the department that the policy forms filing has been deemed approved on a specific date, or advise when the policy forms

filing is withdrawn from consideration. Deemed approval shall not be effective until the *insurer* has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

5. No insurer, or officer, employee or representative of an insurer, shall file a Certification of Compliance containing false attestations, or from which material facts or information have been omitted. In the event that the department subsequently learns that a Certification of Compliance contained any inaccuracies, false attestations, or material omissions, approval of the subject forms may be withdrawn, and the insurer may be subjected to the provisions of Subsection I hereof.

G. Resubmission of Filings

1. When submitting revised forms in response to an order of disapproval, or withdrawal of approval, whether issued pursuant to Subsection E, Subsection F or Subsection I hereof, the revised forms will constitute a new filing; must comply with all provisions of this Section for such a filing; and, in addition to the required filing fee, must include:

a. an outline of the proposed revisions, referencing the specific sections and page numbers for each form being revised;

b. a restatement of the form with all necessary revisions, as set forth in the prior order of disapproval, underlined in red or similarly emphasized; and

c. a copy of the prior order of disapproval, or withdrawal of approval, issued by the department on the previous filing.

2. When submitting revisions to previously approved forms, the revised forms will constitute a new filing; must be a complete filing as set forth in Subsection C hereof, "General Filing Requirements"; and, in addition to the required filing fee, must include:

a. a copy of the previously approved form;

b. an outline of the proposed revisions, referencing the specific sections and page numbers for each previously approved form being revised;

c. a restatement of the form, with all proposed revisions underlined in red or similarly emphasized; and

d. a copy of the prior order of approval, issued by the department on the previous filing.

3. For simplicity, it is advisable that a unique form number be assigned to a substantially rewritten form, and that such form be filed as an original filing.

H. Compliance and Audits

1. Approval of a basic insurance policy form does not assure perpetual compliance. Following subsequent changes in applicable law, insurers shall not fail to revise and file updated insurance products, or amendatory riders or endorsements where appropriate, with the department for approval as required to maintain continuous compliance with the current requirements of law. This provision shall apply to all new business issued, or in-force business renewed, following any such subsequent changes in applicable law, or as otherwise determined by the Louisiana Legislature.

2. A retrospective review process will be utilized to verify compliance of approved filings and to assure that all approved filings remain in compliance with currently applicable law. Compliance audits may be conducted by random selection, prompted by complaints filed with the department or requests for information made by the department, or performed during the course of examinations conducted by the department.

3. Insurers shall notify the department in writing to advise when a previously approved basic insurance policy form will no longer be marketed in this state and is being permanently withdrawn from the market. Such notification shall also advise whether or not coverage issued in this state under the policy form remains in force and whether or not such existing business will continue to be renewed. The notification shall provide the policy form numbers. being discontinued and dates originally approved by the department.

I. Withdrawal of Approval and Corrective Action

1. The department shall withdraw any affirmative approval of a filing previously granted, or withdraw any approval of a filing previously deemed approved by an insurer, if the department determines that any of the reasons for disapproval as stated in R.S. 22:621 apply to the filing in question. The notice of withdrawal of approval by the department shall state that such withdrawal of approval is effective 30 days after receipt of such notice by the affected insurer.

a. The affected insurer may request a hearing on the withdrawal of approval, by written request mailed to the department within 30 days of receipt of the notice of withdrawal of approval.

b. Upon receipt by the department of a request for a hearing, the 30-day notice period precedent to withdrawal of approval being effective shall be suspended for the duration of the hearing process, and shall recommence upon the date of a ruling adverse to the insurer requesting the hearing. Such suspension of the notice of withdrawal of approval shall be applicable to Paragraphs I.2, 3, 4 and 5 hereof.

2. Upon receipt of the notice of withdrawal of approval by the department, the affected insurer must:

a. immediately amend its procedures to assure that all in-force business is properly administered in accordance with the findings stated in the withdrawal of approval;

b. immediately review and ascertain any negative impact upon covered persons caused directly or indirectly by non-compliant provisions of the forms for which approval has been withdrawn; and

c. immediately review other products being marketed by the insurer to assure that they do not contain such non-compliant provisions.

3. Within 30 days of receipt of the notice of withdrawal of approval by the department, a corrective action plan must be submitted to the department by the affected insurer. The corrective action plan must include the following.

a. If the affected product will no longer be marketed, amendatory endorsement forms or rider forms to affect any in-force business written utilizing the non-compliant forms, correcting all areas of non-compliance as stated in the withdrawal of approval by the department; and a prototype of the notice to be utilized in notifying any affected policyholders of the changes to their existing coverage.

b. If the insurer desires to continue marketing the affected product, both:

i. a complete filing of properly revised forms in accordance with Paragraph G.1 hereof; and

ii. amendatory endorsement forms or rider forms to affect any in-force business written utilizing the non-compliant forms, correcting all areas of non-compliance as stated in the withdrawal of approval by the department; and a prototype of the notice to be utilized in notifying any affected policyholders of the changes to their existing coverage.

c. Where such a required change can be clearly explained to prospective policy holders through amendatory endorsement forms or rider forms. Such approval shall not extend to any reprinting of such forms.

4. As of 30 days following receipt of the notice of withdrawal of approval by the department, an affected product shall not be issued by the insurer, except in accordance with a corrective action plan approved by the department. The insurer has the obligation to timely notify its marketing force, or to otherwise adjust its business operations, accordingly.

5. The department may, in its discretion, extend the 30-day period for approval of a corrective action plan, upon the written request of the affected insurer and for good cause shown. In the event such an extension is granted, the date by which the insurer must cease issuing the affected product, except in accordance with a corrective action plan approved by the department, shall likewise be so extended.

6. Failure to timely respond as required herein shall result in a formal investigation to establish the extent of statutory violations, followed by an administrative hearing to determine appropriate sanctions against the insurer.

7. Where the department fails to respond to a corrective action plan filed by an insurer, or takes no action whatsoever regarding such plan, the insurer may deem the subject corrective action plan approved at the expiration of the 30-day period for approval by the department.

J. Appeals; Hearings. Any insurer or other person aggrieved by a failure to approve any filing, or the disapproval of any filing, or the withdrawal of approval of any filing, or any related action taken by the department pursuant to this Section, may request an administrative hearing in accordance with the provisions of Part XXIX of Title 22 of the Louisiana Revised Statutes. pursuant to R.S. 22:1351, such demand must be in writing, must specify in what respects the company is aggrieved and the grounds to be relied upon as basis for relief to be demanded at the hearing, and must be made within 30 days of receipt of actual notice or, if actual notice is not received, within 30 days of the date such insurer or other person learned of the act, or failure to act, upon which the demand for hearing is based.

K. Maintenance of Records; Alteration of Forms Prohibited

1. Every insurer or other person filing policy forms, or related forms, for approval by the department shall maintain in their files the original set of any and all forms as returned by the department, along with all related correspondence and transmittal documents from the department. Alternatively, images of such documents may be maintained in electronic/digital form. Such files shall be available for inspection by the department upon request, and must be maintained until the forms have been withdrawn from the market in accordance with Paragraph H.3 hereof and no coverage issued on risks in this state utilizing such forms remains in force.

2. The alteration of, or any change to, any such form approved by the department is prohibited. Any such altered or changed form shall be submitted to the department as a new filing, and shall comply with all provisions of this Section applicable to a new filing. This Subsection shall not apply to typographical corrections and format improvements that do not affect the terms, provisions or clarity of the product.

3. A change of company name or logo, a change of address, and changes in listed officers do not require a new filing of forms when the department is otherwise properly notified of such change, and a copy of such notification is maintained on file by the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and *Directive* 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2539 (December 2002).

§10109. Filing and Review of Life and Annuity Insurance Policy Forms and Related Matters

A. Definitions. As used in this Section, the following terms shall have the meaning or definition as indicated herein.

Affirmative Approval—department approval, as a result of the department taking action, following compliance review of a complete filing, or a filing pursuant to Subsection D hereof.

Association—an organization which has been formed for purposes other than procuring insurance for the members or employees.

Basic Insurance Policy Form—an insurance contractual agreement delineating the terms, provisions and conditions of a particular insurance or annuity product. It includes certificates of coverage, application forms where written application is required and is to be attached to the policy or be a part of the contract, and any life or health and accident rider or endorsement form. It does not include policies, riders, or endorsements designed, at the request of the individual policyholder, contract holder, or certificate holder, to delineate insurance coverage 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.

Certification of Compliance—certification by an insurer, executed by an officer or authorized representative of the insurer on a form prescribed by the department, that upon knowledge and belief a filing is complete and in compliance with all applicable statutes, and rules and regulations promulgated by the department. A Certification of Compliance must be included with any filing for Certified Approval.

Certified Approval—expedited approval by the department of a complete filing based upon the inclusion of a Statement of Compliance and a Certification of Compliance, executed by an officer or authorized representative of the filing insurer on forms prescribed by the department. The department shall by directive determine those specific types of coverage and particular types of contracts for which the certified approval procedure is either required or available at the option of the insurer.

Complete Filing—the filing of a single insurance product, including any required filing fees, a basic insurance policy form, application form and supplemental application form, if any, to be attached to the policy or be a part of the contract, any life or health and accident rider or endorsement forms, all items required under Subsection C hereof, "General Filing Requirements," and any other requirements as may be set forth in the applicable Statement of Compliance.

Compliance Audit—a retrospective review conducted by the department of previously approved basic insurance policy forms to determine compliance with applicable law.

Compliance Review—department review of a filing made pursuant to this Section to determine either that the filing is in compliance with all applicable statutes, rules and regulations, or that the filing should be disapproved for noncompliance.

Deemed Approval—approval of a complete filing based upon notice, as provided herein, made to the department by the filing *insurer*, following expiration of the specific time periods as provided herein, where affirmative approval has not been granted and the filing has not been disapproved by the department.

Department—the Louisiana Department of Insurance, and includes the Commissioner of Insurance.

Endorsement—a written agreement attached to an insurance product to add or subtract coverage, or otherwise modify the product.

Insurance Product—a basic insurance policy form delineating the terms, provisions and conditions of a specific type of coverage under a particular type of contract.

Insurer—every person engaged in the business of making contracts of insurance, as further defined in R.S. 22:5. As used in this Section, insurer shall also include fraternal benefit societies.

Method of Marketing—marketing either through independent or captive agents; telephone, e-mail or direct mail solicitation; groups, organizations, associations or trusts; and/or the Internet.

Required Filing Fee—the fee assessed per product or filing pursuant to state insurance law.

Rider—an endorsement to an insurance product that modifies clauses and provisions of the product, including adding or excluding coverage.

Statement of Compliance—a form prescribed by the department detailing the requirements specific to a particular form of coverage and contract type.

Trust—a fund established by an employer, two or more employers, a labor union, or an association, pursuant to a trust instrument which transfers title to property and/or funds to one or more trustees to be administered as fiduciaries for the benefit of others.

B. Filing Required

1. Pursuant to R.S. 22:620.A, no basic insurance policy form, 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 rider or endorsement form, may be issued or delivered in this state unless and until it has been filed with and approved by the Commissioner of Insurance. This requirement applies to any group life insurance policy or annuity covering residents of Louisiana where issued or delivered in Louisiana. Every page of each such form, including rider and endorsement forms, filed with the department must be identified by a form number in the lower left corner of the page.

2. A Life and Annuity Transmittal Document must accompany every filing, describing the items included in the filing, the insurance or annuity product for which the filing is being made, and the method of marketing to be used for the product. If the filing will include health insurance to be offered as an optional benefit under the base life insurance contract, the policy forms should be submitted in triplicate, notwithstanding the provisions of Paragraph C.2 hereof, and include the appropriate Statement of Compliance for said health insurance product.

C. General Filing Requirements

1. The department shall designate, by directive, those insurance or annuity products which must be filed pursuant to the requirements for certified approval as set forth in Subsection F hereof, "Time Periods and Requirements for Certified Approval of Policy Form Filings." A directive issued pursuant to this Subsection may also designate those

insurance or annuity products which may, at the discretion of the insurer, be filed either pursuant to said requirements for certified approval, or as ordinary filings subject to review as set forth in Subsection E hereof. All insurance or annuity products not so designated shall be filed pursuant to the requirements for compliance review as set forth in Subsection E hereof, "Time Periods and Requirements for Compliance Review of Basic Insurance Policy Forms."

2. Other than as specified in Subsection D hereof, "Exceptions," only complete filings will be accepted, whether by mail or as otherwise authorized. In order for the department to conduct a proper compliance review or compliance audit of an insurance or annuity product, all items associated therewith must be included. A filing will be determined incomplete and will be disapproved if it does not contain all applicable items.

a. All filings of individual life insurance or annuity products must include, in final wording, the following items, in order:

i. required filing fee, per insurance or annuity product, per company;

ii. completed Life and Annuity Transmittal Document, a prescribed by the department;

iii. Statement of Compliance for said product;

iv. policy forms filed for approval, in duplicate;

v. application form, in duplicate;

vi. rider or endorsement forms, in duplicate;

vii. actuarial memorandum describing the statutory reserves and non-forfeiture values that will be used for each plan of insurance, in duplicate;

viii. life illustrations, if illustrated, in duplicate; and

ix. stamped, self-addressed envelope of sufficient size for use in returning the company's set of the policy forms filed, unless filed electronically.

b. Filings of all group life and annuity products must include, in final wording, the following:

i. required filing fee, per insurance or annuity product, per insurance company;

ii. completed Life and Annuity Transmittal Document, as prescribed by the department;

iii. Statement of Compliance for said product;

iv. group master contract, in duplicate;

v. individual certificate, in duplicate;

vi. group application, in duplicate;

vii. rider or endorsement forms, in duplicate;

viii. employee/member enrollment forms, in duplicate;

ix. actuarial memorandum describing the statutory reserves and non-forfeiture values that will be used for each plan of insurance, in duplicate; and

x. stamped, self-addressed envelope of sufficient size for use in returning the company's set of the policy forms filed, unless filed electronically.

c. Filings of group life and annuity products intended for issue to an association are limited to associations as defined herein, and must include the association's constitution, by-laws, membership application, membership agreement and brochure of membership benefits other than the insurance products offered.

d. Filings of group life and annuity products intended for issuance to a trust are limited to trusts established by an employer or association and must include the trust agreement, articles of incorporation or other instrument creating the trust, and member adoption agreement. If the trust was established by an association, include the information described in Subparagraph C.2.c hereof. This Subsection shall not apply not apply to trusts established by qualified or government pension plans.

e. Filings of amendatory riders or endorsements as needed to bring into compliance with law any existing insurance or annuity products that have been previously approved and are currently in force, but are no longer being marketed, must include specimen copies of the previously approved forms, the dates previously approved, and the specific terms and provisions being amended, underlined in red or otherwise noted. The transmittal letter should advise that the previously approved form is no longer being marketed.

D. Exceptions. Exceptions to the requirements for a complete filing may be allowed, at the discretion of the department, subject to the conditions stated herein, for the following policy forms.

1. Application forms to be used with a particular insurance or annuity product, or with multiple insurance or annuity products, provided that the policy form filings and dates approved are identified for each previously approved product with which the application form will henceforth be used and, the application form is included with any subsequently filed basic insurance or annuity policy forms as needed to constitute a complete filing. No filings fees will be required for these filings.

2. Assumption certificates, which must be filed in duplicate, with a single copy of the assumption agreement, letter of domiciliary state approval, information fully identifying the block of business being assumed, the number of covered lives residing in the state of Louisiana to be affected by the assumption, and the effective date of the assumption. No filing fees will be required for these filings.

3. Riders or endorsement forms affecting previously approved life insurance or annuity products, provided that the policy form filings and dates approved are identified for each previously approved product with which the rider or endorsement form will henceforth be used. No filing fees will be required for these filings. The rider or endorsement forms shall be included with any subsequently filed basic insurance policy forms as needed to constitute a complete filing.

4. Forms for lines of insurance or insurance products specifically exempted pursuant to statute.

E. Time Periods and Requirements for Compliance Review of Basic Insurance Policy Forms

1. The time periods stated in this Section do not begin until the date a complete filing, or a filing pursuant to Subsection D hereof, "Exceptions," is received by the department.

2. If a filing made is incomplete, notice of disapproval in accordance with R.S. 22:621(6) will be issued for failure to comply with the requirements of this regulation.

3. A basic insurance policy form must be submitted to the department in accordance with the General Filing Requirements of this Section no less than 45 days in advance of planned issuance, delivery or use.

4. If affirmatively approved by the department prior to expiration of the 45-day period allowed for department review of a filing, the policy forms filed may be used on or after the date approved.

5. If disapproved, the policy forms filed may not be used.

6. At the expiration of 45 days, if no order has been issued affirmatively approving or disapproving a filing, the insurer may submit written notice to the department that the filing has been deemed approved on a specific date, or advise when the filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

7. The Commissioner of Insurance may send written notice prior to expiration of the initial 45-day period extending the time allowed for approval or disapproval by an additional 15 days.

a. If affirmatively approved by order of the commissioner prior to expiration of the 15-day extended period allowed for department review, the policy forms filed may be used on or after the date approved.

b. At the expiration of the 15-day extended period, if no order has been issued affirmatively approving or disapproving the policy form filing, the insurer may submit written notice to the department that the policy forms filing has been deemed approved on a specific date, or advise when the policy forms filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

F. Time Periods and Requirements for Certified Approval of Policy Form Filings

1. The department will make available "Statements of Compliance" setting forth the statutory and regulatory requirements specific to the various forms of coverage and contract types, as well as Certification of Compliance forms.

2. A policy form filing submitted for certified approval must include the following documents:

a. Statement of Compliance applicable to the form of coverage and contract type being submitted;

b. signed and dated Certification of Compliance;

c. all other items as set forth in Paragraph C.2 hereof.

3. If the filing is incomplete, notice of disapproval in accordance with R.S. 22:621(6) will be issued for failure to comply with the requirements of this regulation.

4. At the expiration of 15 days from acknowledged receipt of a filing by the department, if no order has been issued affirming certified approval or disapproving the policy form filing, the insurer may submit written notice to the department that the policy forms filing has been deemed approved on a specific date, or advise when the policy forms filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

5. No insurer, or officer, employee or representative of an insurer, shall file a Certification of Compliance containing false attestations, or from which material facts or information have been omitted. In the event that the department subsequently learns that a Certification of Compliance contained any inaccuracies, false attestations, or material omissions, approval of the subject forms may be withdrawn, and the insurer may be subjected to the provisions of Subsection I hereof.

G. Resubmission of Filings

1. When submitting revised forms in response to an order of disapproval, or withdrawal of approval, whether issued pursuant to Subsection E, Subsection F or Subsection I hereof, the revised forms will constitute a new filing; must be a complete filing as set forth in Subsection C hereof, "General Filing Requirements"; and, in addition to the required filing fee, must include:

a. an outline of the proposed revisions, referencing the specific sections and page numbers for each form being revised;

b. a restatement of the form with all necessary revisions, as set forth in the prior order of disapproval, underlined in red or similarly emphasized; and

c. a copy of the prior order of disapproval, or withdrawal of approval, issued by the department on the previous filing.

2. When submitting revisions to previously approved forms, the revised forms will constitute a new filing; must be a complete filing as set forth in Subsection C hereof, "General Filing Requirements"; and, in addition to the required filing fee, must include:

a. a copy of the previously approved form;

b. an outline of the proposed revisions, referencing the specific sections and page numbers for each previously approved form being revised;

c. a restatement of the form, with all proposed revisions underlined in red or similarly emphasized; and

d. a copy of the prior order of approval, issued by the department on the previous filing.

3. For simplicity, it is advisable that a unique form number be assigned to a substantially rewritten form, and that such form be filed as an original filing.

H. Compliance and Audits

1. Approval of a basic insurance policy form does not assure perpetual compliance. Following subsequent changes in applicable law, insurers shall not fail to revise and file updated insurance products, or amendatory riders or endorsements where appropriate, with the department for approval as required to maintain continuous compliance with the current requirements of law. This provision shall apply to all new business issued, or in-force business renewed, following any such subsequent changes in applicable law, or as otherwise determined by the Louisiana Legislature.

2. A retrospective review process will be utilized to verify compliance of approved filings and to assure that all approved filings remain in compliance with currently applicable law. Compliance audits may be conducted by random selection, prompted by complaints filed with the department or requests for information made by the department, or performed during the course of examinations conducted by the department.

3. Insurers shall notify the department in writing to advise when a previously approved basic insurance policy form will no longer be marketed in this state and is being permanently withdrawn from the market. Such notification shall also advise whether or not coverage issued in this state under the policy form remains in force and whether or not such existing business will continue to be renewed. The notification shall provide the policy form numbers being discontinued and dates originally approved by this department.

I. Withdrawal of Approval and Corrective Action

1. The department shall withdraw any affirmative approval of a filing previously granted, or withdraw any approval of a filing previously deemed approved by an insurer, if the department determines that any of the reasons for disapproval as stated in R.S. 22:621 apply to the filing in question. The notice of withdrawal of approval by the department shall state that such withdrawal of approval is effective 30 days after receipt of such notice by the affected insurer.

a. The affected insurer may request a hearing on the withdrawal of approval, by written request mailed to the department within 30 days of receipt of the notice of withdrawal of approval.

b. Upon receipt by the department of a request for a hearing, the 30-day notice period precedent to withdrawal of approval being effective shall be suspended for the duration of the hearing process, and shall recommence upon the date of a ruling adverse to the insurer requesting the hearing. Such suspension of the notice of withdrawal of approval shall be applicable to Paragraphs I.2, 3, 4 and 5 hereof.

2. Upon receipt of the notice of withdrawal of approval by the department, the affected insurer must:

a. immediately amend its procedures to assure that all in-force business is properly administered in accordance with the findings stated in the withdrawal of approval;

b. immediately review and ascertain any negative impact upon covered persons caused directly or indirectly by non-compliant provisions of the forms for which approval has been withdrawn; and

c. immediately review other products being marketed by the insurer to assure that they do not contain such non-compliant provisions.

3. Within 30 days of receipt of the notice of withdrawal of approval by the department, a corrective action plan must be submitted to the department by the affected insurer. The corrective action plan must include the following.

a. If the affected product will no longer be marketed, amendatory endorsement forms or rider forms to affect any in-force business written utilizing the non-compliant forms, correcting all areas of non-compliance as stated in the withdrawal of approval by the department; and a prototype of the notice to be utilized in notifying any affected policyholders of the changes to their existing coverage.

b. If the insurer desires to continue marketing the affected product, both:

i. a complete filing of properly revised forms in accordance with Paragraph G.1 hereof; and

ii. amendatory endorsement forms or rider forms to affect any in-force business written utilizing the non-compliant forms, correcting all areas of non-compliance as stated in the withdrawal of approval by the department; and a prototype of the notice to be utilized in notifying any affected policyholders of the changes to their existing coverage.

c. Where such a required change can be clearly explained to prospective policyholders through amendatory endorsement forms or rider forms, an insurer may request department approval to utilize its existing inventory of the policy forms in question subject to the incorporation of approved amendatory endorsement forms or rider forms. Such approval shall not extend to any reprinting of such forms.

4. As of 30 days following receipt of the notice of withdrawal of approval by the department, an affected product shall not be issued by the insurer, except in accordance with a corrective action plan approved by the department. The insurer has the obligation to timely notify its marketing force, or to otherwise adjust its business operations, accordingly.

5. The department may, in its discretion, extend the 30-day period for approval of a corrective action plan, upon the written request of the affected insurer and for good cause shown. In the event such an extension is granted, the date by which the insurer must cease issuing the affected product, except in accordance with a corrective action plan approved by the department, shall likewise be so extended.

6. Failure to timely respond as required herein shall result in a formal investigation to establish the extent of statutory violations, followed by an administrative hearing to determine appropriate sanctions against the insurer.

7. Where the department fails to respond to a corrective action plan filed by an insurer, or takes no action whatsoever regarding such plan, the insurer may deem the subject corrective action plan approved at the expiration of the 30-day period for approval by the department.

J. Appeals; Hearings. Any insurer or other person aggrieved by a failure to approve any filing, or the disapproval of any filing, or the withdrawal of approval of any filing, or any related action taken by the department pursuant to this Section, may request an administrative hearing in accordance with the provisions of Part XXIX of Title 22 of the Louisiana Revised Statutes. pursuant to R.S. 22:1351, such demand must be in writing, must specify in what respects the company is aggrieved and the grounds to be relied upon as basis for relief to be demanded at the hearing, and must be made within 30 days of receipt of actual notice or, if actual notice is not received, within 30 days of the date such insurer or other person learned of the act, or failure to act, upon which the demand for hearing is based.

K. Maintenance of Records; Alteration of Forms Prohibited

1. Every insurer or other person filing policy forms, or related forms, for approval by the department shall maintain in their files the original set of any and all forms as returned by the department, along with all related correspondence and transmittal documents from the department. Alternatively, images of such documents may be maintained in electronic/digital form. Such files shall be available for inspection by the department upon request, and must be maintained until the forms have been withdrawn from the market in accordance with Paragraph H.3 hereof and no coverage issued on risks in this state utilizing such forms remains in force.

2. The alteration of, or any change to, any such form approved by the department is prohibited. Any such altered or changed form shall be submitted to the department as a new filing, and shall comply with all provisions of this Section applicable to a new filing. This Subsection shall not apply to typographical corrections and format improvements that do not affect the terms, provisions or clarity of the product.

3. A change of company name or logo, a change of address, and changes in listed officers do not require a new filing of forms when the department is otherwise properly notified of such change, and a copy of such notification is maintained on file by the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and *Directive* 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2544 (December 2002).

§10113. Filing and Review of Property and Casualty Insurance Policy Forms and Related Matters

A. Definitions. As used in this Section, the following terms shall have the meaning or definition as indicated herein.

Affirmative Approval—department approval, as a result of the department taking action, following Compliance Review of a complete filing, or a filing pursuant to Subsection D hereof.

Basic Insurance Policy Form—an insurance contractual agreement delineating the terms, provisions and conditions of a particular insurance product. It includes endorsements, and application forms where written application is required and is to be attached to the policy or be a part of the contract. It does not include policies, riders., or endorsements designed, at the request of the individual policyholder, contract holder, or certificate holder, to delineate insurance coverage 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.

Certification of Compliance—certification by an insurer, executed by an officer or authorized representative of the insurer on a form prescribed by the department, that upon knowledge and belief a filing is complete and in compliance with all applicable statutes, and rules and regulations promulgated by the department. A Certification of Compliance must be included with any filing for certified approval.

Certified Approval—expedited approval by the department of a complete filing based upon the inclusion of a Statement of Compliance and a Certification of Compliance, executed by an officer or authorized representative of the filing insurer on forms prescribed by the department. The department shall by Directive determine those specific types of coverage and particular types of contracts for which the Certified Approval procedure is either required or available at the option of the insurer.

Complete Filing—the filing of a single insurance product, including any required filing fees, a basic insurance policy form, application form to be attached to the policy or be a part of the contract, all items required under Subsection C hereof, "General Filing Requirements," and any other requirements as may be set forth in the applicable Statement of Compliance.

Compliance Audit—a retrospective review conducted by the department of previously approved basic insurance policy forms to determine compliance with applicable law.

Compliance Review—department review of a filing made pursuant to this Section to determine either that the filing is in compliance with all applicable statutes, rules and regulations, or that the filing should be disapproved for noncompliance.

Deemed Approval—approval of a complete filing based upon notice, as provided herein, made to the department by the filing insurer, following expiration of the specific time periods as provided herein, where Affirmative approval has not been granted and the filing has not been disapproved by the department.

Department—the Louisiana Department of Insurance, and includes the Commissioner of Insurance.

Endorsement—a written agreement attached to an insurance product to add or subtract coverage, or otherwise modify the product.

Filing Organization—an entity authorized by the Louisiana Insurance Rating Commission to act as an advisory or rating organization on behalf of its members and subscribers.

Insurance Product—a basic insurance policy form delineating the terms, provisions and conditions of a specific type of coverage under a particular type of contract, or a basic insurance policy form which combines more than one line of business within one policy form at a single premium.

Insurer—every person engaged in the business of making contracts of insurance, as further defined in R.S. 22:5.

Method of Marketing—marketing either through independent or captive agents; telephone, e-mail or direct mail solicitation; groups, organizations, associations or trusts; and/or the Internet.

Rate/Rule Approval—a department notice addressed to an insurer granting authorization to implement or revise rates and/or rules on a specified date.

Required Filing Fee—the fee assessed per product or filing pursuant to state insurance law.

Rider—an endorsement to an insurance product that modifies clauses and provisions of the product, including adding or excluding coverage.

Statement of Compliance—a form prescribed by the department detailing the requirements specific to a particular form of coverage and contract type.

B. Filing Required

1. Pursuant to R.S. 22:620.A, no basic insurance policy form, other than surety bond forms, or application form where written application is required and is to be attached to the policy or be a part of the contract, or printed rider or endorsement form, may be issued or delivered in this state unless and until it has been filed with and approved by the Commissioner of Insurance. Every page of each such form, including rider and endorsement forms, filed with the department must be identified by a form number in the lower left corner of the page.

2. A Property and Casualty Transmittal Document must accompany every filing, describing the items included in the filing, the insurance product for which the filing is being made, and the method of marketing to be used for the product.

C. General Filing Requirements

1. The department shall designate, by directive, those insurance products which must be filed pursuant to the requirements for certified approval as set forth in Subsection F hereof, "Time Periods and Requirements for Certified Approval of Policy Form Filings," and those insurance products which may, at the discretion of the insurer, be filed pursuant to said requirements. All insurance products not so designated shall be filed pursuant to the requirements for Compliance Review as set forth in Subsection E hereof, "Time Periods and Requirements for Compliance Review of Policy Form Filings." Filing organizations are excepted from the mandatory provisions relative to Certified Approval and may, at their option, make filings pursuant to Subsection E hereof.

2. Only complete filings will be accepted, whether by mail or as otherwise authorized. In order for the department to conduct a proper compliance review or compliance audit of an insurance product, all items associated therewith must be included. A filing of a basic insurance policy form will be determined incomplete and will be disapproved if it does not contain all applicable items.

a. All filings of an insurance product must include, in final wording, the following items, in order:

i. required filing fee, per product, per insurance company; or required filing fee per endorsement filing; per insurance company;

ii. forms filed for approval;

iii. completed Property and Casualty Transmittal Document, as prescribed by the department;

iv. Statement of Compliance for said product;

v. duplicate set of the policy forms filing, as filed for approval;

vi. explanation of any rate/rule impact, with a copy of any rate/rule approval letters issued by the department; if none, so state;

vii. stamped, self-addressed envelope of sufficient size for use in returning the company's set of the policy forms filed, unless filed electronically.

3. An insurer may elect to adopt forms submitted by a filing organization, or have a filing organization file forms on its behalf. An insurer may request an effective date later than the effective date of the filing by the filing organization. Such adoptions, whether delayed or not, must be requested by letter. The Forms and Compliance Division staff of the department will verify that the insurer is a member or subscriber of the filing organization, and that the forms being adopted have been approved by the department.

a. Adoptions, including delayed adoptions, are filed for informational purposes only, but the request will be denied if the forms proposed for adoption are not approved by the department. To receive an acknowledgement of filing, the insurer's request must contain the following items, in order:

i. required filing fee, per adoption, per insurance company whether or not delayed;

ii. reference to the filing organization's identification/code number;

iii. line of business;

iv. name of the program; and

v. stamped, self-addressed envelope of sufficient size for use in returning the insurer's cover letter bearing the department's stamp of acknowledgement, or disapproval of an adoption.

b. An insurer may elect to non-adopt forms submitted by a filing organization. Non-adoptions are filed for informational purposes only, and must be submitted by the insurer. To receive an acknowledgement of the informational letter, it must contain the following items, in order:

i. reference to the filing organization's identification/code number;

ii. line of business;

iii. name of the program; and

iv. stamped, self-addressed envelope of sufficient size for use in returning the insurer's cover letter bearing the department's stamp of acknowledgement.

D. Exceptions. Exceptions to the requirements for a complete filing may be allowed, at the discretion of the department, subject to the conditions stated herein, for the following policy forms:

1. informational filings, submitted for acknowledgement, for surety bond forms as exempted by R.S. 22:620 A(1);

2. filings for certain commercial lines, exempted pursuant to the commercial deregulation laws set by Regulation 72;

3. application forms to be used with a particular insurance product, or with multiple insurance products, provided that the policy form filings and dates approved are identified for each previously approved product with which the application form will henceforth be used, and the application form is included with any subsequently filed basic insurance policy forms as needed to constitute a complete filing. No filing fees will be required for these filings;

4. forms for lines of insurance or insurance products specifically exempted pursuant to statute.

E. Time Periods and Requirements for Compliance Review of Policy Form Filings

1. The time periods stated in this Section do not begin until the date a complete filing, or a filing pursuant to Subsection D hereof, "Exceptions," is received by the department.

2. If a filing made is incomplete, notice of disapproval in accordance with R.S. 22:621(6) will be issued for failure to comply with the requirements of this regulation.

3. A basic insurance policy form must be submitted to the department in accordance with the General Filing Requirements of this Section no less than 45 days in advance of planned issuance, delivery or use.

4. If affirmatively approved by order of the commissioner prior to expiration of the 45-day period allowed for department review of a filing, the policy forms filed may be used on or after the date approved.

5. If disapproved, the policy forms filed may not be used.

6. At the expiration of 45 days, if no order has been issued affirmatively approving or disapproving a filing, the insurer may submit written notice to the department that the filing has been deemed approved on a specific date, or advise when the filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

7. The Commissioner of Insurance may send written notice prior to expiration of the initial 45-day period extending the time allowed for approval or disapproval by an additional 15 days.

a. If affirmatively approved by order of the commissioner prior to expiration of the 15-day extended period allowed for department review, the policy forms filed may be used on or after the date approved.

b. At the expiration of the 15-day extended period, if no order has been issued affirmatively approving or disapproving the policy form filing, the insurer may submit written notice to the department that the policy forms filing has been deemed approved on a specific date or, advise when the policy forms filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

F. Time Periods and Requirements for Certified Approval of Policy Form Filings

1. The department will make available Statements of Compliance setting forth the statutory and regulatory requirements specific to the various forms of coverage and contract types, as well as Certification of Compliance forms.

2. A policy form filing submitted for certified approval must include the following documents.

a. Statement of Compliance applicable to the form of coverage and contract type being submitted.

b. Signed and dated Certification of Compliance.

c. All other items as set forth in Paragraph C.2 hereof.

3. If the filing is incomplete, notice of disapproval in accordance with R.S. 22:621(6) will be issued for failure to comply with the requirements of this regulation.

4. At the expiration of 15 days from acknowledged receipt of a filing by the department, if no order has been issued affirming certified approval or disapproving the policy form filing, the insurer may submit written notice to the department that the policy form filing has been deemed approved on a specific date, or advise when the policy form filing is withdrawn from consideration. Deemed approval shall not be effective until the insurer has so notified the department, by either ordinary mail, facsimile transmission or electronic mail.

5. No insurer, or officer, employee or representative of an insurer, shall file a Certification of Compliance containing false attestations, or from which material facts or information have been omitted. In the event that the department subsequently learns that a Certification of Compliance contained any inaccuracies, false attestations, or material omissions, approval of the subject forms may be withdrawn, and the insurer may be subjected to the provisions of Subsection I hereof.

G. Resubmission of Filings

1. When submitting revised forms in response to an order of disapproval, or withdrawal of approval, whether issued pursuant to Subsection E, Subsection F or Subsection I hereof, the revised forms will constitute a new filing; must comply with all provisions of this Section for such a filing; and, in addition to the required filing fee, must include:

a. an outline of the proposed revisions, referencing the specific sections and page numbers for each form being revised;

b. a restatement of the form with all necessary revisions, as set forth in the prior order of disapproval, underlined in red or similarly emphasized; and

c. a copy of the prior order of disapproval, or withdrawal of approval, issued by the department on the previous filing.

2. When submitting revisions to previously approved forms, the revised forms will constitute a new filing; must be a complete filing as set forth in Subsection C hereof, "General Filing Requirements"; and, in addition to the required filing fee, must include:

a. a copy of the previously approved form;

b. an outline of the proposed revisions, referencing the specific sections and page numbers for each previously approved form being revised;

c. a restatement of the form, with all proposed revisions underlined in red or similarly emphasized; and

d. a copy of the prior order of approval, issued by the department on the previous filing.

3. For simplicity, it is advisable that a unique form number be assigned to a substantially rewritten form, and that such form be filed as an original filing.

H. Compliance and Audits

1. Approval of a basic insurance policy form does not assure perpetual compliance. Following subsequent changes in applicable law, insurers shall not fail to revise and file updated insurance products, or amendatory riders or endorsements where appropriate, with the department for approval as required to maintain continuous compliance with the current requirements of law. This provision shall apply to all new business issued, or in-force business renewed, following any such subsequent changes in applicable law, or as otherwise determined by the Louisiana Legislature.

2. A retrospective review process will be utilized to verify compliance of approved filings and to assure that all approved filings remain in compliance with currently applicable law. Compliance audits may be conducted by random selection, prompted by complaints filed with the department or requests for information made by the department, or performed during the course of examinations conducted by the department.

3. Insurers shall notify the department in writing to advise when a previously approved basic insurance policy form will no longer be marketed in this state and is being permanently withdrawn from the market. Such notification shall be sent 30 days prior to the market end date and shall also advise whether or not coverage issued in this state under the policy form remains in force and whether or not such existing business will continue to be renewed. The notification shall provide the policy form numbers being discontinued and dates originally approved by this department. The insurer may request acknowledgement of such notification.

I. Withdrawal of Approval and Corrective Action

1. The department shall withdraw any affirmative approval of a filing previously granted, or withdraw any approval of a filing previously deemed approved by an insurer, if the department determines that any of the reasons for disapproval as stated in R.S. 22:621 apply to the filing in question. The notice of withdrawal of approval by the department shall state that such withdrawal of approval is effective 30 days after receipt of such notice by the affected insurer.

a. The affected insurer may request a hearing on the withdrawal of approval, by written request mailed to the department within 30 days of receipt of the notice of withdrawal of approval.

b. Upon receipt by the department of a request for a hearing, the 30-day notice period precedent to withdrawal of approval being effective shall be suspended for the duration of the hearing process, and shall recommence upon the date of a ruling adverse to the insurer requesting the hearing. Such suspension of the notice of withdrawal of approval shall be applicable to Paragraphs I.2, 3, 4, and 5 hereof.

2. Upon receipt of the notice of withdrawal of approval by the department, the affected insurer must:

a. immediately amend its procedures to assure that all in-force business is properly administered in accordance with the findings stated in the withdrawal of approval;

b. immediately review and ascertain any negative impact upon covered persons caused directly or indirectly by non-compliant provisions of the forms for which approval has been withdrawn; and

c. immediately review other products being marketed by the insurer to assure that they do not contain such non-compliant provisions.

3. Within 30 days of receipt of the notice of withdrawal of approval by the department, a corrective action plan must be submitted to the department by the affected insurer. The corrective action plan must include the following.

a. If the affected product will no longer be marketed, amendatory endorsement forms or rider forms to affect any in-force business written utilizing the non-compliant forms, correcting all areas of non-compliance as stated in the withdrawal of approval by the department; and a prototype of the notice to be utilized in notifying any affected policyholders of the changes to their existing coverage.

b. If the insurer desires to continue marketing the affected product, both:

i. a complete filing of properly revised forms in accordance with Paragraph G.1 hereof; and

ii. amendatory endorsement forms or rider forms to affect any in-force business written utilizing the non-compliant forms, correcting all areas of non-compliance as stated in the withdrawal of approval by the department; and a prototype of the notice to be utilized in notifying any affected policyholders of the changes to their existing coverage.

c. Where such a required change can be clearly explained to prospective policy holders through amendatory endorsement forms or rider forms, an insurer may request department approval to utilize its existing inventory of the policy forms in question subject to the incorporation of approved amendatory endorsement forms or rider forms. Such approval shall not extend to any reprinting of such forms.

4. As of 30 days following receipt of the notice of withdrawal of approval by the department, an affected product shall not be issued by the insurer, except in accordance with a corrective action plan approved by the department. The insurer has the obligation to timely notify its marketing force, or to otherwise adjust its business operations, accordingly.

5. The department may, in its discretion, extend the 30-day period for approval of a corrective action plan, upon the written request of the affected insurer and for good cause shown. In the event such an extension is granted, the date by which the insurer must cease issuing the affected product, except in accordance with a corrective action plan approved by the department, shall likewise be so extended.

6. Failure to timely respond as required herein shall result in a formal investigation to establish the extent of statutory violations, followed by an administrative hearing to determine appropriate sanctions against the insurer.

7. Where the department fails to respond to a corrective action plan filed by an insurer, or takes no action whatsoever regarding such plan, the insurer may deem the subject corrective action plan approved at the expiration of the 30-day period for approval by the department.

J. Appeals; Hearings. Any insurer or other person aggrieved by a failure to approve any filing, or the disapproval of any filing, or the withdrawal of approval of any filing, or any related action taken by the department pursuant to this Section, may request an administrative hearing in accordance with the provisions of Part XXIX of Title 22 of the Louisiana Revised Statutes. Pursuant to R.S. 22:1351, such demand must be in writing, must specify in what respects the company is aggrieved and the grounds to be relied upon as basis for relief to be demanded at the hearing, and must be made within 30 days of receipt of actual notice or, if actual notice is not received, within 30 days of the date such insurer or other person learned of the act, or failure to act, upon which the demand for hearing is based.

K. Maintenance of Records; Alteration of Forms Prohibited

1. Every insurer or other person filing policy forms, or related forms, for approval by the department shall maintain in their files the original set of any and all forms as returned by the department, along with all related correspondence and transmittal documents from the department. Alternatively, images of such documents may be maintained in electronic/digital form. Such files shall be available for inspection by the department upon request, and must be maintained until the forms have been withdrawn from the market in accordance with Paragraph H.4 hereof and no coverage issued on risks in this state utilizing such forms remains in force.

2. The alteration of, or any change to, any such form approved by the department is prohibited. Any such altered or changed form shall be submitted to the department as a new filing, and shall comply with all provisions of this Section applicable to a new filing. This Subsection shall not apply to typographical corrections and format improvements that do not affect the terms, provisions or clarity of the product.

3. A change of company name or logo, a change of address, and changes in listed officers do not require a new filing of forms when the department is otherwise properly notified of such change, and a copy of such notification is maintained on file by the insurer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and *Directive* 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2548 (December 2002).

§10115. Penalties

A. Pursuant to R.S. 22:1462.1, "False or Fraudulent Material Information," in accordance with all provisions thereof, and specifically applicable to all documents required by this regulation.

1. 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.

2. 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 $5,000, or both.

B. Pursuant to R.S. 22:1214(12), in accordance with all provisions thereof, any violation of a prohibitory provision of this regulation shall constitute an unfair trade practice, and, after proper notice and hearing as specified by statute, may subject the insurer and its officer(s) or representative(s) to:

1. the provisions of R.S. 22:1217, including:

a. payment of a monetary penalty of not more than $1,000. for each and every act or violation, but not to exceed an aggregate penalty of $100,000 unless the person knew or reasonably should have known he was in violation of applicable law, in which case the penalty shall be not more than $25,000 for each and every act or violation, but not to exceed an aggregate penalty of $250,000 in any six-month period; and,

b. suspension or revocation of the license of the person if he knew or reasonably should have known he was in violation of applicable law.

2. The provisions of R.S. 22:1217.1, including:

a. a monetary penalty of not more than $25,000 for each and every act or violation, not to exceed an aggregate of $250,000; and

b. suspension or revocation of such person's license or certificate of authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and *Directive* 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2552 (December 2002).

§10117. Effective Date

A. This regulation shall become effective on January 1, 2003, or upon final publication in the *Louisiana Register* if after that date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and *Directive* 169.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:2552 (December 2002).

Chapter 103. Regulation 79—Limited Licensing for Motor Vehicle Rental Companies

§10301. Purpose

A. The purpose of this regulation is:

1. to implement the qualifications and procedures for licensing motor vehicle rental or leasing companies to sell or offer insurance in conjunction with the rental of a vehicle;

2. to govern the transactions of selling travel or automobile related products or coverage in conjunction with and incidental to the rental of vehicles.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:932 (April 2005).

§10303. Definitions

A. For the purposes of this regulation the following terms shall have the meaning ascribed herein, unless the context clearly indicates otherwise.

Commissioner—the Commissioner of Insurance.

Department—the Department of Insurance.

Detailed Plan of Operation or *Plan*—a comprehensive overview of the licensee's rental business pursuit in so far as it is regulated by the Department of Insurance. This information will supplement the restricted license application and will be on forms provided by the department.

Limited Licensee—a person or entity authorized to sell certain coverage relating to the rental of vehicles pursuant to the provisions of Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950.

Part—Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:2101 through 2112.

Rental Agreement—any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

Rental Company—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 90 days.

Rental Period—the term of the rental agreement.

Renter—any person or entity obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

Vehicle or *Rental Vehicle*—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 26,000 pounds and which do not require the operator to possess a commercial driver's license.

a. Pursuant to R.S. 32:408B, Classes of licenses, this provision includes as a "vehicle" or "rental vehicle" those motor vehicles which require the operator to possess a Class "D" Chauffeur's License.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:932 (April 2005).

§10305. Issuance of Limited License—in General

A. Prior to approval, an applicant for a limited license issued to a motor vehicle rental company or franchisee of a motor rental company shall at a minimum:

1. submit an application on forms prescribed by the commissioner;

2. pay the applicable fee required by this Part;

3. provide a detailed plan of operation pursuant to §10307.B of this regulation;

4. provide an insurance sales material disclosure pursuant to §10307.C of this regulation;

5. provide a training program or syllabus and train all employees pursuant to §10307.D of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:932 (April 2005).

§10307. Limited Licensing; Application, Supplements, Requirements

A. Applicants for a rental company limited license shall apply to the Commissioner of Insurance on forms established by the commissioner. The application may request any information deemed necessary by the commissioner, including but not limited to the following:

1. the applicant's corporate, firm, or other business entity name, the business address and telephone number of the principal place of business and the business address and telephone number of each additional location at which the applicant will transact business under the license;

2. all assumed business names and other names under which the applicant will engage in business under the license;

3. the names of the employees, its agents, members, partners, officers, directors and stockholders of the applicant personally engaged in this state in soliciting or negotiating insurance in conjunction with the rental of a vehicle;

4. a declaration by the applicant that the applicant:

a. is competent and trustworthy;

b. intends to act in good faith;

c. has a good business reputation;

d. has the appropriate experience, training or education that qualifies the applicant for the license applied for;

e. has or will train all employees to be involved in the sale, offering, or negotiation of coverage prior to their conducting such activities with members of the public;

5. the application shall be signed by an officer of the applicant.

B. The application for this limited license shall be supplemented by a detailed plan of operation to be submitted on forms prescribed by the commissioner, which shall request information deemed necessary, including but not limited to:

1. name of any appointing insurer(s), if applicable;

2. the lines of business the applicant intends to write; including:

a. personal accident insurance;

b. liability;

c. personal effects;

d. roadside assistance;

e. emergency sickness; or

f. any other travel or auto related coverage in connection with or incidental to rental transaction;

3. a list of all business locations within Louisiana from which business will be conducted under the license.

C. The application for this limited license shall be supplemented with a copy of the licensee's proposed Insurance Sales Material Disclosure as required by the Louisiana Insurance Code, which at a minimum shall:

1. be received by the department prior to its use and be subject to approval by the department;

2. summarize clearly and correctly, the material terms of coverage offered to renters, including the identity of insurer(s), if applicable;

3. disclose that 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;

4. state that purchasing the kinds of coverage specified in this Part is not required when renting a vehicle;

5. describe the claims filing process.

D. The application for this limited license shall be supplemented with a copy of the licensee's proposed training program or syllabus as required by the Louisiana Insurance Code. The training program required by this Part shall:

1. be received by the department prior to its use and be subject to approval by the department;

2. include basic instruction about the kinds of coverage offered under the license;

3. include the following items:

a. renters of vehicles are not required to purchase the coverage offered through the licensee as a condition of renting a vehicle;

b. renters must be informed that coverage offered by the licensee may duplicate existing coverage of the renter and that the renter should consult with his or her insurance producer if the renter has any questions about existing coverage;

c. the rental period of the rental agreement can not exceed 90 consecutive days;

d. claims procedures;

e. the identity of any insurance company providing coverage offered by the licensee;

f. evidence of coverage in the rental agreement must be disclosed to every renter who elects to purchase such coverage;

g. employees of the licensee are not authorized to evaluate a renter's existing coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:932 (April 2005).

§10309. Renewals

A. A limited license expires on the last day of the month in which the second anniversary of the initial issuance occurs. Thereafter, the limited license shall expire on the second anniversary following each renewal.

B. Prior to expiration, the licensee shall notify the commissioner of its intention to continue the license on forms provided by the commissioner and shall submit the applicable renewal fee as set forth in this Part. Late filings will be assessed a late fee as authorized by R.S. 22:1078.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:933 (April 2005).

§10311. Limitations of License

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 pre-selection 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. A 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.

1. The limited licensee shall keep a list of all persons who are authorized or who are selling insurance as provided herein. The list shall be produced to the commissioner within two weeks of written demand from the commissioner.

C. No limited licensee under this Part shall advertise, represent, or otherwise hold itself or any of its employees or agents out as licensed insurers or insurance producers.

1. The sale of insurance not in conjunction with a rental transaction is prohibited by the provisions of Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, §2101 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:933 (April 2005).

§10313. Insurance Charges

A. Notwithstanding any other provision of this Part or any rule adopted by the commissioner, a limited licensee pursuant to Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, §2101 et seq., shall not be required to treat monies collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction is prohibited by the provisions of this Part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:934 (April 2005).

§10315. Penalties for Violations

A. In the event that any provision of Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, §2101 et seq., 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 $1,000 for each violation, up to $100,000 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 purpose of this Part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:934 (April 2005).

§10317. Applicability

A. All limited licensees under Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, §2101 et seq shall be subject to all other applicable provisions of this Title unless specifically exempted by Part XVII of Chapter 2 of Title 22 of the Louisiana Revised Statutes of 1950, §2101 et. seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 31:934 (April 2005).

§10319. Severability

A. If any provision or item of this regulation, or the application thereof, is held to be invalid, such invalidity shall not affect other provisions, items, or applications of the regulation, which can be given effect without the invalid provisions, item, or application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2112, and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 31:934 (April 2005).

Chapter 105. Regulation Number 83—Domestic Insurer's Use of Custodial Agreements and the Use of Clearing Corporations

§10501. Definitions

A. When used in this regulation, the term:

Agent—a national bank, state bank, trust company or broker/dealer that maintains an account in its name in a clearing corporation or that is a member of the Federal Reserve System and through which a custodian participates in a clearing corporation, including the Treasury/Reserve Automated Debt Entry Securities System (TRADES) or treasury direct systems, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, *agent* may include a corporation that is organized or existing under the laws of a foreign country and that is legally qualified under those laws to accept custody of securities.

Clearing Corporation—a corporation, as defined in Section 8-102(a)(5) of the Uniform Commercial Code, that is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, *clearing corporation* may include a corporation that is organized or existing under the laws of a foreign country and which is legally qualified under those laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes "Treasury/Reserve Automated Debt Entry Securities System" and "Treasury Direct" book-entry securities systems established pursuant to 31 U.S.C. §3100 et seq., 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301.

Custodian—

a. a national bank, state bank or trust company that shall at all times during which it acts as a custodian pursuant to this regulation be no less than adequately capitalized as determined by the standards adopted by United States banking regulators and that is regulated by either state banking laws or is a member of the Federal Reserve System and that is legally qualified to accept custody of securities in accordance with the standards set forth below, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country, or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, *custodian* may include a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as such by that country's government or an agency thereof that shall at all times during which it acts as a custodian pursuant to this regulation be no less than adequately capitalized as determined by the standards adopted by international banking authorities and that is legally qualified to accept custody of securities; or

b. a broker/dealer that shall be a member of the National Association of Security Dealers, registered with and subject to jurisdiction of the Securities and Exchange Commission, maintains membership in the Securities Investor Protection Corporation, has an agency office in this state and has a tangible net worth equal to or greater than $250,000,000.

Custodied Securities—securities held by the custodian or its agent or in a clearing corporation, including the Treasury/Reserve Automated Debt Equity Securities System (TRADES) or treasury direct systems.

Securities' Certificate—has the same meaning as that defined in Section 8-102(a)(16) of the Uniform Commercial Code.

Security—has the same meaning as that defined in Section 8-102(a)(15) of the Uniform Commercial Code.

Tangible Net Worth—shareholders equity, less intangible assets, as reported in the broker/dealer's most recent annual or transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 (S.E.C. Form 10-K) filed with the Securities and Exchange Commission.

Treasury/Reserve Automated Debt Entry Securities System (TRADES) and Treasury Direct—the book entry securities systems established pursuant to 31 U.S.C. §3100 et seq., 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301. The operation of TRADES and treasury direct are subject to 31 C.F.R. pt. 357 et seq.

AUTHORITY NOTE: Promulgated in accordance with Act 342 of the 2004 Louisiana Regular Legislative Session; R.S. 22:39.D; and the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:1092 (May 2005).

§10503. Custody Agreement; Requirements

A. An insurance company may, by written agreement with a custodian, provide for the custody of its securities with that custodian. The securities that are the subject of the agreement may be held by the custodian or its agent or in a clearing corporation.

B. The agreement shall be in writing and shall be authorized by a resolution of the board of directors of the insurance company or of an authorized committee of the board. The terms of the agreement shall comply with the following.

1. Securities' certificates held by the custodian shall be held separate from the securities' certificates of the custodian and of all of its other customers.

2. Securities held indirectly by the custodian and securities in a clearing corporation shall be separately identified on the custodian's official records as being owned by the insurance company. The records shall identify which securities are held by the custodian or by its agent and which securities are in a clearing corporation. If the securities are in a clearing corporation, the records shall also identify where the securities are and if in a clearing corporation, the name of the clearing corporation and if through an agent, the name of the agent.

3. All custodied securities that are registered shall be registered in the name of the company or in the name of a nominee of the company or in the name of the custodian or its nominee or, if in a clearing corporation, in the name of the clearing corporation or its nominee.

4. Custodied securities shall be held subject to the instructions of the insurance company and shall be withdrawable upon the demand of the insurance company, except that custodied securities used to meet the deposit requirements set forth in Section 22:1021 of this insurance law shall, to the extent required by that Section, be under the control of the Louisiana Department of Insurance and shall not be withdrawn by the insurance company without the approval of the Louisiana Department of Insurance.

5. The custodian shall be required to send or cause to be sent to the insurance company a confirmation of all transfers of custodied securities to or from the account of the insurance company. In addition, the custodian shall be required to furnish no less than monthly the insurance company with reports of holdings of custodied securities at times and containing information reasonably requested by the insurance company. If applicable, the custodian's trust committee's annual reports of its review of the insurer's trust accounts shall also be provided to the insurer. Reports and verifications may be transmitted in electronic or paper form.

6. During the course of the custodian's regular business hours, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, the custodian's records relating to custodied securities, but only upon furnishing the custodian with written instructions to that effect from an appropriate officer of the insurance company.

7. The custodian and its agents shall be required to maintain and make available to the insurance company as it may reasonably request:

a. reports which they receive from a clearing corporation on their respective systems of internal accounting control; and

b. reports prepared by outside auditors on the custodians or its agent's internal accounting control of custodied securities.

8. The custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the insurance company's annual statement and supporting schedules and information required in an audit of the financial statements of the insurance company.

9. The custodian shall provide, upon written request from an appropriate officer of the insurance company, the appropriate affidavits, substantially in the form attached to this regulation, with respect to custodied securities.

10. A national bank, state bank or trust company shall secure and maintain insurance protection in an adequate amount covering the bank's or trust company's duties and activities as custodian for the insurer's assets, and shall state in the custody agreement that protection is in compliance with the requirements of the custodian's banking regulator. A broker/dealer shall secure and maintain insurance protection for each insurance company's custodied securities in excess of that provided by the Securities Investor Protection Corporation in an amount equal to or greater than the market value of each respective insurance company's custodied securities. The commissioner may determine whether the type of insurance is appropriate and the amount of coverage is adequate.

11. The custodian shall be obligated to indemnify the insurance company for any loss of custodied securities occasioned by the negligence or dishonesty of the

custodian's officers or employees, or burglary, robbery, holdup, theft or mysterious disappearance, including loss by damage or destruction.

12. In the event that there is a loss of custodied securities for which the custodian shall be obligated to indemnify the insurance company as provided in Paragraph 11 above, the custodian shall promptly replace the securities or the value thereof and the value of any loss of rights or privileges resulting from the loss of securities. Such indemnification does not apply to nor protect against losses from any change in the market value of custodied securities.

13. The agreement may provide that the custodian will not be liable for a failure to take an action required under the agreement in the event and to the extent that the taking of the action is prevented or delayed by war (whether declared or not and including existing wars), revolution, insurrection, riot, civil commotion, act of God, accident, fire, explosion, stoppage of labor, strikes or other differences with employees, laws, regulations, orders or other acts of any governmental authority, or any other cause whatever beyond its reasonable control.

14. In the event that the custodian gains entry in a clearing corporation through an agent, there shall be an agreement between the custodian and the agent under which the agent shall be subject to the same liability for loss of custodied securities as the custodian. However, if the agent shall be subject to regulation under the laws of a jurisdiction that is different from the jurisdiction the laws of which regulate the custodian, the commissioner of insurance of the state of domicile of the insurance company may accept a standard of liability applicable to the agent that is different from the standard of liability applicable to the custodian.

15. The custodian shall provide written notification to the insurer's domiciliary commissioner if the custodial agreement with the insurer has been terminated or if 100 percent of the account assets in any one custody account have been withdrawn. This notification shall be remitted to the insurance commissioner within three business days of the receipt by the custodian of the insurer's written notice of termination or within three business days of the withdrawal of 100 percent of the account assets.

AUTHORITY NOTE: Promulgated in accordance with Act 342 of the 2004 Louisiana Regular Legislative Session; R.S. 22:39.D.; and the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:1093 (May 2005).

§10505. Deposit with Affiliates; Requirements

A. Nothing in this regulation shall prevent an insurance company from depositing securities with another insurance company with which the depositing insurance company is affiliated, provided that the securities are deposited pursuant to a written agreement authorized by the board of directors of the depositing insurance company or an authorized committee thereof and that the receiving insurance company is organized under the laws of one of the states of the United States of America or of the District of Columbia. If the respective states of domicile of the depositing and receiving insurance companies are not the same, the depositing insurance company shall have given notice of the deposit to the insurance commissioner in the state of its domicile and the insurance commissioner shall not have objected to it within 30 days of the receipt of the notice.

B. The terms of the agreement shall comply with the following.

1. The insurance company receiving the deposit shall maintain records adequate to identify and verify the securities belonging to the depositing insurance company.

2. The receiving insurance company shall allow representatives of an appropriate regulatory body to examine records relating to securities held subject to the agreement.

3. The depositing insurance company may authorize the receiving insurance company:

a. to hold the securities of the depositing insurance company in bulk, in certificates issued in the name of the receiving insurance company or its nominee, and to commingle them with securities owned by other affiliates of the receiving insurance company; and

b. to provide for the securities to be held by a custodian, including the custodian of securities of the receiving insurance company or in a clearing corporation.

AUTHORITY NOTE: Promulgated in accordance with Act 342 of the 2004 Louisiana Regular Legislative Session; R.S. 22:39.D.; and the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:1094 (May 2005).

§10507. Custodian Affidavit—Form A

CUSTODIAN AFFIDAVIT

(For use by a custodian where securities entrusted to its care have not been redeposited elsewhere.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ having a place of business at _____ _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That the schedule attached hereto is a true and complete statement of securities (other than those caused to be deposited with The Depository Trust Company or like entity or a Federal Reserve Bank under the TRADES or Treasury Direct systems) which were in the custody of the corporation for the account of the insurance company as of the close of business on _____; that, unless otherwise indicated

on the schedule, the next maturing and all subsequent coupons were then either attached to coupon bonds or in the process of collection; and that, unless otherwise shown on the schedule, all such securities were in bearer form or in registered form in the name of the insurance company or its nominee or of the corporation or its nominee, or were in the process of being registered in such form;

That the corporation as custodian has the responsibility for the safekeeping of such securities as that responsibility is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to

before me this _____ day

of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

AUTHORITY NOTE: Promulgated in accordance with Act 342 of the 2004 Louisiana Regular Legislative Session; R.S. 22:39.D.; and the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:1095 (May 2005).

§10509. Custodian Affidavit—Form B

CUSTODIAN AFFIDAVIT

(For use in instances where a custodian corporation maintains securities on deposit with the Depository Trust Company or like entity.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities of the corporation as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ having a place of business at _____ _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That the corporation has caused certain of such securities to be deposited with _____ and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the corporation was custodian as of the close of business on _____, and which were so deposited on such date;

That the corporation as custodian has the responsibility for the safekeeping of the securities both in the possession of the corporation or deposited with _____ as is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to

before me this _____ day

of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

AUTHORITY NOTE: Promulgated in accordance with Act 342 of the 2004 Louisiana Regular Legislative Session; R.S. 22:39.D.; and the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:1095 (May 2005).

§10511. Custodian Affidavit—Form C

CUSTODIAN AFFIDAVIT

(For use where ownership is evidenced by book entry at a Federal Reserve Bank.)

STATE OF _____)
) ss.
COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "corporation"):

That his or her duties involve supervision of activities of the corporation as custodian and records relating thereto;

That the corporation is custodian for certain securities of _____ with a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the corporation and the insurance company;

That it has caused certain securities to be credited to its book entry account with the Federal Reserve Bank of _____ under the TRADES or Treasury Direct systems; and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the corporation was custodian as of the close of business on _____, which were in a "general" book entry account maintained in the name of the corporation on the books and records of the Federal Reserve Bank of _____ at such date;

That the corporation has the responsibility for the safekeeping of such securities both in the possession of the corporation or in the "general" book entry account as is specifically set forth in the agreement between the corporation as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims or encumbrances whatsoever.

Subscribed and sworn to

before me this _____ day

of _____, 20____

_____ (L.S.)
Vice President [or other authorized officer]

AUTHORITY NOTE: Promulgated in accordance with Act 342 of the 2004 Louisiana Regular Legislative Session; R.S. 22:39.D.; and the Louisiana Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:1095 (May 2005).

Chapter 107. Regulation Number 84—Recognition and Use of the 2001 CSO Mortality Table in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits

§10701. Authority

A. This regulation is promulgated by the commissioner of insurance pursuant to authority granted under the Louisiana Insurance Code, Title 22, §22:1 et seq., particularly the Standard Valuation Law, see Title 22, §163.B(1)(a) and the Standard Nonforfeiture Law for Life Insurance, see Title 22 §168.G(8)(f).

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2541 (October 2005).

§10703. Purpose

A. The purpose of this regulation is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with R.S. 22:163.B(1)(a) (the Standard Valuation Law for Life Insurance), R.S. 22:168.G(8)(f) (the Standard Nonforfeiture Law for Life Insurance) and Sections 10909.A and Sections 10909.B of Regulation 85.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2541 (October 2005).

§10705. Definitions

2001 CSO Mortality Table—that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

2001 CSO Mortality Table (F)—that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

2001 CSO Mortality Table (M)—that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

Composite Mortality Tables—mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

Smoker and Nonsmoker Mortality Tables—mortality tables with separate rates of mortality for smokers and nonsmokers.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2541 (October 2005).

§10707. 2001 CSO Mortality Table

A. At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this regulation, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2005 and before the date specified in Subsection B to which R.S. 22:163.B(1)(a), R.S. 22:168.G(8)(f) and Sections 10909.A and B of Regulation 85 are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes. Notwithstanding the preceding, the commissioner may specify restrictions on the use of this table for certain categories of life insurance for which the use of this table's mortality assumption is not representative of the business' underlying mortality experience.

B. Subject to the conditions stated in this regulation, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which R.S. 22:163.B(1)(a), R.S. 22:168.G(8)(f) and Sections 10909.A and B of Regulation 85 are applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2542 (October 2005).

§10709. Conditions

A. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

1. composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

2. smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by R.S. 22:163.B(8)(a) and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

3. smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. For plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

C. For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of Section 10911 of Regulation 85 relative to use of the select and ultimate form.

D. When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in §2109.A.1 of Regulation 47 of the Louisiana Insurance Regulations. A commissioner may exempt a company from this requirement if it only does business in this state and in no other state.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2542 (October 2005).

§10711. Applicability of the 2001 CSO Mortality Table to Regulation 85

A. The 2001 CSO Mortality Table may be used in applying Regulation 85 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in §10707 of this regulation.

1. Section 10905.A.(2).(b): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

2. Section 10907: All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in §10909.B of this regulation. The value of "$q_{x+k+t-1}$" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

3. Section 10909.A: The 2001 CSO Mortality Table is the minimum standard for basic reserves.

4. Section 10909.B: The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in Sections 10909.B.3.a. through i. In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant actuarial standards of practice.

5. Section 10911.C: The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

6. Section 10911.E.4: The calculations specified in §10911.E shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

7. Section 10911.F.4: The calculations specified in §10911.F shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

8. Section 10911.G.2: The calculations specified in §10911.G shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

9. Section 10913.A.1.b: The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

B. Nothing in this Section shall be construed to expand the applicability of Regulation 85 to include life insurance policies exempted under §10905.A of Regulation 85.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2542 (October 2005).

§10713. Gender-Blended Tables

A. For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2005, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this Subsection of the regulation.

B. The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the NAIC in December 2002.

C. It shall not, in and of itself, be a violation of R.S. 22:1211 et seq. for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§10715. Separability

A. If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

§10717. Effective Date

A. The approximate effective date for this regulation is November 1, 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2543 (October 2005).

Chapter 109. Regulation Number 85—Valuation of Life Insurance Policies

§10901. Purpose

A. The purpose of this regulation is to provide:

1. tables of select mortality factors and rules for their use;

2. rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

3. rules concerning a minimum standard for the valuation of plans with secondary guarantees.

B. The method for calculating basic reserves defined in this regulation will constitute the commissioners' reserve valuation method for policies to which this regulation is applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2550 (October 2005).

§10903. Authority

A. This regulation is promulgated by the commissioner of insurance pursuant to authority granted under the Louisiana Insurance Code, Title 22, Section 22:1 et seq., particularly the Standard Valuation Law, see Title 22, §163.B.1.a and the Standard Nonforfeiture Law for Life Insurance, see Title 22 §168.G.(8)(f).

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2550 (October 2005).

§10905. Applicability

A. This regulation shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this regulation, subject to the following exceptions and conditions.

1. Exceptions

a. This regulation shall not apply to any individual life insurance policy issued on or after the effective date of this regulation if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this regulation, that guarantees the premium rates of the new policy. This regulation also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

b. This regulation shall not apply to any universal life policy that meets all the following requirements:

i. secondary guarantee period, if any, is five years or less;

ii. specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the *CSO valuation tables* as defined in §10907 and the applicable valuation interest rate; and

iii. the initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

c. This regulation shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

d. This regulation shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

e. This regulation shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

2. Conditions

a. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of §10911.

b. Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of §10913.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2550 (October 2005).

§10907. Definitions

A. For purposes of this regulation:

Basic Reserves—reserves calculated in accordance with R.S. 22:163.B.(4)(a).

Contract Segmentation Method—

a. the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the *1980 CSO valuation tables*, as defined in this Section, (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after the effective date of this regulation and promulgated by regulation by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in §10909.B of this regulation;

b. the length of a particular contract segment shall be set equal to the minimum of the value *t* for which G_t is greater than R_t (if G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, ...; *t* is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount for year *t* of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}},$$ However, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one;

where:

x, k and t are as defined above, and

qx+k+t-1 = valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of §10909B.2 if §10909B.3 is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

Deficiency Reserves—the excess, if greater than zero, of:

a. minimum reserves calculated in accordance with R.S. 22:163.B.(8)(a); over

b. basic reserves.

Guaranteed Gross Premiums—the premiums under a policy of life insurance that are guaranteed and determined at issue.

Maximum Valuation Interest Rates—the interest rates defined in R.S. 22:163.B.(3)(a) are to be used in determining the minimum standard for the valuation of life insurance policies.

1980 CSO Valuation Tables—the Commissioners 1980 Standard Ordinary Mortality Table (1980 CSO Table) without 10-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

Scheduled Gross Premium—the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in §10913.A.3, if any, or else the minimum premium described in §10913.A.4.

Segmented Reserves—reserves calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

a. the present value of the death benefits within the segment; plus

b. the present value of any unusual guaranteed cash value (see §10911.D) occurring at the end of the segment; less

c. any unusual guaranteed cash value occurring at the start of the segment; plus

d. for the first segment only, the excess of the Clause i over Clause ii, as follows:

i. a net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the

net level annual premium on the 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy;

ii. a net one year term premium for the benefits provided for in the first policy year;

e. the length of each segment is determined by the *contract segmentation method*, as defined in this Section;

f. the interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy;

g. for both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

Tabular Cost of Insurance—the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

Ten-Year Select Factors—the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

Unitary Reserves—

a. the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

i. guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

ii. modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of Subclause (a) over Subclause (b), as follows:

(a). a net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy;

(b). a net one year term premium for the benefits provided for in the first policy year;

b. the interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

Universal Life Insurance Policy—any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2550 (October 2005).

§10909. General Calculation Requirements for Basic Reserves and PremiumDeficiency Reserves

A. At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for this purpose). If select mortality factors are elected, they may be:

1. the 10-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

2. the select mortality factors in §10915; or

3. any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating basic reserves.

B. Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any subsequent valuation mortality table adopted by the NAIC once promulgated by regulation by the commissioner). If select mortality factors are elected, they may be:

1. the 10-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

2. the select mortality factors in §10915 of this regulation;

3. for durations in the first segment, X percent of the select mortality factors in §10915, subject to the following:

a. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

b. X shall not be less than 20 percent;

c. X shall not decrease in any successive policy years;

d. X is such that, when using the valuation interest rate used for basic reserves, Clause i is greater than or equal to Clause ii:

i. the actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

ii. the actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

e. X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five years after the valuation date;

f. the appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Paragraph B.3;

g. the appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of Paragraph B.3; and

h. the appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums;

i. if X is less than 100 percent at any duration for any policy, the following requirements shall be met:

i. the appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of §2111 of Regulation 47; and

ii. the appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of Paragraph B.3. This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience;

4. any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating deficiency reserves.

C. This Subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than 10 years, the appropriate 10-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

D. In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

E. Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following:

1. reserves calculated ignoring the guarantee;

2. reserves assuming the guarantee was made at issue; and

3. reserves assuming that the policy was issued on the date of the guarantee.

F. The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of §2111.A.2 of Regulation 47.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2552 (October 2005).

§10911. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)

A. Basic Reserves. Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in Paragraph 1 or 2 below may be made.

1. Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

2. Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

B. Deficiency Reserves

1. The deficiency reserve at any duration shall be calculated:

a. on a unitary basis if the corresponding basic reserve determined by Subsection A is unitary;

b. on a segmented basis if the corresponding basic reserve determined by Subsection A is segmented; or

c. on the segmented basis if the corresponding basic reserve determined by Subsection A is equal to both the segmented reserve and the unitary reserve.

2. This Subsection shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in §10909.B) and rate of interest.

3. Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in §10909.B.

4. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

C. Minimum Value. Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the 10-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policy-owner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

D. Unusual Pattern of Guaranteed Cash Surrender Values

1. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

2. The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

a. *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

i. the date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

ii. the mandatory expiration date of the policy; and

b. the net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

c. the net to gross ratio is equal to Clause i divided by Clause ii as follows:

i. the present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the n year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period;

ii. the present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period.

3. For purposes of this Subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

a. 110 percent of the scheduled gross premium for that year;

b. 110 percent of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

c. 5 percent of the first policy year surrender charge, if any.

E. Optional Exemption for Yearly Renewable Term Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used.

1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection C.

3. Deficiency Reserves

a. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph a above.

4. For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without 10-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

5. A reinsurance agreement shall be considered YRT reinsurance for purposes of this Subsection if only the mortality risk is reinsured.

6. If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

F. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used.

1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in §10911.C.

3. Deficiency Reserves

a. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph a above.

4. For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without 10-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

5. A policy shall be considered an attained-age-based YRT life insurance policy for purposes of this Subsection if:

a. the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

b. the premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

6. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

a. the initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

b. the initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

c. after the initial period of coverage, the policy meets the conditions of Paragraph 5 above.

7. If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this regulation.

G. Exemption from Unitary Reserves for Certain *n*-Year Renewable Term Life Insurance Polices. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

1. the policy consists of a series of *n*-year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, n may be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

2. the guaranteed gross premiums in all *n*-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the 10-year select mortality factors; and

3. there are no cash surrender values in any policy year.

H. Exemption from Unitary Reserves for Certain Juvenile Policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

1. at issue, the insured is age 24 or younger;

2. until the insured reaches the end of the juvenile period, which shall occur at or before age 25, the gross premiums and death benefits are level, and there are no cash surrender values; and

3. after the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2553 (October 2005).

§10913. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies that Contain Provisions Resulting in the Ability of a Policy Owner to Keep a Policy in Force over a Secondary Guarantee Period

A. General

1. Policies with a secondary guarantee include:

a. a policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

b. a policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without 10-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose; or

c. a policy with any combination of Subparagraph a and b.

2. A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in Subsections B and C below shall be recalculated from issue to reflect these changes.

3. Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

4. For purposes of this Section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

5. The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in §10909.B.2, 3, and 4 may not be used to calculate the one-year valuation premiums.

6. The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

B. Basic Reserves for the Secondary Guarantees. Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the *contract segmentation method* as defined in §10907.

C. Deficiency Reserves for the Secondary Guarantees. Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in §10911.B with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

D. Minimum Reserves. The minimum reserves during the secondary guarantee period are the greater of:

1. the basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

2. the minimum reserves required by other rules or regulations governing universal life plans.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2555 (October 2005).

§10915. Select Mortality Factors—Appendix

A. This appendix contains tables of select mortality factors that are the bases to which the respective percentage of §§10909.A2, 10909.B.2 and 10909.B.3 are applied.

B. The six tables of select mortality factors contained herein include:

1. male aggregate;

2. male nonsmoker;

3. male smoker;

4. female aggregate;

5. female nonsmoker; and

6. female smoker.

C. These tables apply to both age last birthday and age nearest birthday mortality tables.

D. For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are 80 percent of the appropriate male table in this Appendix, plus 20 percent of the appropriate female table in this Appendix.

Select Mortality Factors

Male, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100

Male, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100

Male, Aggregate																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Aggregate																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100

Male, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100

Male, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100

Male, Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100

Male, Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Aggregate																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100

Female, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100

Female, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Aggregate																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100

Female, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100

Female, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100

Female, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female, Smoker																				
Issue	**Duration**																			
Age	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20+**
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

NOTES:
Legislative History (all references are to the Proceedings of the NAIC).
1994 Proc. 4th Quarter 17, 26, 653, 1098, 1126-1159 (adopted).
1998 Proc. 4th Quarter 15-16, 17, 608, 978, 1126-1148 (amended and reprinted).

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2556 (October 2005).

§10917. Effective Date

A. The proposed effective date for this regulation is November 1, 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:163, 22:168 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2566 (October 2005).

Chapter 111. Regulation 86—Dependent Coverage of Newborn Children in the Group and Individual Market

§11101. Authority

A. This regulation is issued pursuant to the authority vested in the commissioner under the provisions of R.S. 49:953 of the Administrative Procedure Act, R.S. 22:3 and 22:250.2(E)(2)(b) and (c), and R.S. 22:250.4.F, and 22:250.11.E and 22:250.15.A, regarding the coverage of a newborn child as a dependent in the group and individual health insurance market and to provide for related matters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2259 (September 2005).

§11103. Purpose

A. The purpose of this regulation is to establish reasonable requirements and standards for the processing of such coverage by health insurance issuers that assures compliance with state requirements under Title 22 of the Louisiana Revised Statutes of 1950, as amended. More specifically, this regulation is necessary to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and R.S. 22:250.4.F, and 22:250.11.E and 22:250.15.A of Part VI-C of Chapter 1 of Title 22.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2260 (September 2005).

§11105. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation shall apply to health insurance issuers, including health maintenance organizations, as required pursuant to R.S. 22:2001 et seq., of the Louisiana Revised Statutes of 1950, as amended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2260 (September 2005).

§11107. Definitions

A. As used in this regulation, these terms shall have the following meaning.

Cancellation for Nonpayment of Premium—the cancellation of coverage for a newborn child who was added as a dependent due to the nonpayment of the applicable premium adjustment for the additional coverage for the newborn child within the time frames established by law or in this regulation.

Effective Date of Birth—the date of the moment of live birth of a newborn child.

Eligibility Provisions—a newborn child who meets the requirements set forth in the State Plan Medical Assistance under Title XIX of the Social Security Act.

Health Care Facility—a facility or institution providing health care services including, but not limited to, a hospital (specifically including a neonatal special care unit) or other licensed inpatient center, ambulatory surgical or treatment center, diagnostic, laboratory, or imaging center, or rehabilitation or other therapeutic health setting.

Health Care Provider—a physician or other health care practitioner licensed, certified or registered to perform specified health care services consistent with state law.

Health Insurance Issuer—an insurance company, including a health maintenance organization as defined and licensed to engage in the business of insurance under Part XII of Chapter 2 of Title 22 of the Louisiana Revised Statutes, unless preempted as a qualified employee benefit plan under the Employee Retirement Income Security Act of 1974.

Newborn Child—an infant from the time of birth through and until such time as the infant is discharged from a health care facility to his or her home.

Non-Qualifying Newborn Child—a newborn child who does not meet the eligibility requirements of the State Plan Medical Assistance under Title XIX of the Social Security Act.

Notice of Cancellation—the written notice sent from the health insurance issuer to the Secretary of the Department of Health and Hospitals by certified mail, return receipt requested, with regard to the cancellation of coverage for a newborn child. This notice of cancellation may, as a courtesy, also be sent via electronic means to the Secretary of the Department of Health and Hospitals; however, such electronic notice shall not satisfy the notice requirement set forth in the enabling statute that requires the notice of

cancellation be sent by certified mail, return receipt requested, to the Secretary of the Department of Health and Hospitals.

Qualifying Newborn Child—a newborn child who meets the eligibility provisions of the State Plan Medical Assistance under Title XIX of the Social Security Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2260 (September 2005).

§11109. Enrollment Notification Procedures for a Qualifying Newborn Child

A. Upon notification of the birth of a newborn child who is potentially eligible under Title XIX of the Social Security Act, the health insurance issuer shall be required to:

1. verify that dependant coverage is available for the newborn child or make a determination that no coverage is available for the newborn child;

2. make a determination of the benefit limits with regard to the newborn child;

3. make a determination of any additional premium, if applicable, that may be due in order to provide dependent coverage for the newborn child; and

4. designate a point of contact (which may be a specific position), with telephone number and physical address, to represent the health insurance issuer to facilitate all matters relative to the newborn child.

B. Upon notification of the birth of a newborn child who is potentially eligible under Title XIX of the Social Security Act, the health insurance issuer shall be required to notify the following persons:

1. with regard to an individual policy, the policyholder;

2. with regard to a group policy, both the employer and the employee;

3. with regard to either an individual policy or a group policy, the health care facility that rendered any medical service to the newborn child from the moment of birth until such time as the infant is discharged from said health care facility to his or her home.

C. The notification that the health insurance issuer is required to send to the persons referred to in Subsection B above shall include the following information:

1. verification as to whether the health plan provides coverage under which the newborn child could be enrolled as a dependent or, if such coverage is not available under the health care plan, an explanation of why such coverage is not available;

2. the additional amount of premium due, if any, in order to provide dependent coverage for the newborn child;

3. designate a point of contact (which may be a specific position), with telephone number and physical address, to represent the health insurance issuer to facilitate all matters relative to the newborn child; and

4. statement to the policyholder under an individual policy or the employee and employer under a group plan that additional information is needed by the health insurance issuer. A health insurance issuer may request that the signature of the policyholder of an individual policy or employee and employer under a group plan be on the enrollment form. However, the failure of the policyholder or employee or employer, as applicable, to place a signature on the enrollment form shall not be a requirement for the enrollment of the newborn child, as the newborn child is enrolled as a matter of law.

D. The health insurance issuer shall be required to provide 90 days written notice to the Secretary of the Department of Health and Hospitals prior to the cancellation of health coverage for a potential qualifying newborn child. This notice shall provide the following documents and/or information:

1. the group identification/policy number or the individual identification/policy number, as applicable, including, but not limited to, the major medical identification number and the prescription drug identification number;

2. summary of benefits, including, but not limited to, an itemization of all covered benefits and applicable co-payments and deductibles;

3. amount of additional premium due in order to provide dependent coverage for the newborn child, including, but not limited to, the total premium (month or portion of a month) due to effectuate coverage for the newborn child from the date of birth;

4. the name(s) of the member subscriber of the newborn child, including, but not limited to, the name(s) of any and all other dependent(s) and the effective date of coverage for each person(s) named as a dependent;

5. designate a point of contact (which may be a specific position), with telephone number and physical address, to represent the health insurance issuer to facilitate all matters relative to the newborn child.

E. Additionally, no later than three days after the mailing of the written notice to the Secretary of the Department of Health and Hospitals referred to in Subsection D above, the health insurance issuer shall provide the same documents and/or information to any and all health care facilities and any and all health care providers who, prior to or on the date of the notice of cancellation, have either:

1. submitted a claim to the health insurance issuer for health care services rendered to the newborn child; or

2. provided notice to the health insurance issuer that it is rendering or has rendered health care services to the newborn child.

F. The Secretary of the Department of Health and Hospitals shall have 90 days, commencing the day after the

secretary receives the written notice, via certified mail, return receipt requested, from the health insurance issuer as provided in Subsection D above, to pay the applicable additional premium attributable to the newborn child to retain the newborn child as a covered dependent under the policy of health insurance.

G. If that portion of the applicable additional premium attributable to the newborn child being retained as a covered dependent under the policy of health insurance remains unpaid after the expiration of the 90 day written notice time period referred to in Subsection E above to the Secretary of Department of Health and Hospitals, the health insurance issuer may thereafter cancel the dependent coverage for the newborn child effective as of the date of birth of the newborn child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2260 (September 2005).

§11111. Procedures for a Non-Qualifying Newborn Child

A. The health insurance issuer shall be required to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 with regard to the enrollment procedures relative to dependent coverage for a non-qualifying newborn child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2261 (September 2005).

§11113. Timely Payment of Claims

A. In cases where the time for the payment of a claim may be effected by the requirements of R.S. 22:250.4 et seq., such requirements shall be considered "just and reasonable grounds" for a health insurance issuer to delay in the payment of a claim pursuant to R.S. 22:250.31 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2261 (September 2005).

§11115. Sanctions

A. A health insurance issuer that does not comply with any of the time limits for action or notice set forth in this regulation, or who does not provide all of the information required in this regulation, shall be subject to the sanctions set forth in R.S. 22:1457.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2261 (September 2005).

§11117. Severability

A. If any Section or provision of this regulation or the application to any person or circumstance is held invalid, such invalidity or determination shall not affect other Sections or provisions or the application of this regulation to any persons or circumstances that can be given effect without the invalid Section or provision or application, and for these purposes the Sections and provisions of this regulation and the application to any persons or circumstances are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2262 (September 2005).

§11119. Effective Date

A. This regulation shall be effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 to implement and enforce the provisions of R.S. 22:250.2.E.(2)(b) and (c), and 22:250.4.F, and 22:250.11.E, and 22:250.15.A of Part VI-C of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, as amended.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2262 (September 2005).

Chapter 113. Regulation 88—Standardization of Health Benefits and Compliance Requirements for LaChoice

§11301. Purpose

A. The purpose of this regulation is:

1. to implement the statutory requirements in establishing pilot health insurance programs to increase access to affordable health insurance for small employers and for individuals pursuant to R.S. 22:244 et seq., of the Louisiana Revised Statutes of 1950; and

2. to carry out the intent of the Legislature and assure full compliance with the applicable statutory provisions by establishing procedures for the standardization of health benefits and compliance requirements. This program and the applicable statutory authority relating thereto shall be referred to hereinafter as "LaChoice."

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following

provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2948 (November 2005).

§11303. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation shall apply to health insurance issuers that choose to offer health insurance under the provisions of LaChoice as required pursuant to R.S. 22:244 et seq., of the Louisiana Revised Statutes of 1950.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2948 (November 2005).

§11305. Eligibility, Benefits and Underwriting Criteria

A. In order to participate in LaChoice, employers must not have provided group health insurance coverage to their employees for at least six months from the date the last policy of insurance was terminated or nonrenewed.

B. The commissioner of insurance shall have the authority via regulation to alter the above time period in accordance with R.S. 22:246(1).

C. In order to participate in LaChoice, a health insurance issuer shall be required to file all proposed health insurance policy forms with the Department of Insurance for review and approval. Such policies shall be in compliance with Regulation 78. A statement of compliance is not required.

D. Policies issued pursuant to the provisions of LaChoice shall be exempted from all state benefit mandates, including but not limited to those mandates contained in R.S. 22:213.2.A, R.S.22:215.1.B, R.S.22:215.8, R.S. 22:215.10, R.S. 22:215.11.A, R.S. 22:215.11.B, R.S. 22:215.14, R.S. 22:215.15, R.S. 22:215.16, R.S. 22:215.20, R.S. 22:215.21, R.S. 22:215.22, R.S. 22:215.24, R.S. 22:228.7, R.S. 22:230.4, R.S. 22:669, R.S. 22:2004.1 and R.S. 22:2004.2.

E. All such health insurance coverage shall meet the requirements of Part VI-C of Title 22 except as specifically enumerated by statute or regulation. Any waiting period imposed shall be in compliance with Part VI-C of Title 22.

F. Policies issued pursuant to the provisions of LaChoice shall be exempted from R.S. 22:250.4(F)(1), (2) and (3), and R.S. 22:250.15(A)(2), (3), (4) and (5) unless dependent coverage is offered pursuant to LaChoice policies. If dependent coverage is offered, the provisions of R.S. 22:250.4(F)(1), (2) and (3), and R.S. 22:250.15(A)(2), (3), (4) and (5) shall apply to LaChoice policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2948 (November 2005).

§11307. Participation Requirement

A. The health insurance issuer shall provide to the Department of Health and Hospitals through electronic means via a current ANSI X12N 834 transaction format pursuant to the HIPAA transactions and code sets requirements, an initial enrollment roster for each employer group listing employees who are to be covered by the health insurance issuer.

B. The initial enrollment roster for each employer group will include all employees who are to be covered by the health insurance issuer regardless of whether or not the employee is eligible for the LaChoice premium subsidy pursuant to §11311.

C. The health insurance issuer shall provide monthly employee update transactions to the Department of Health and Hospitals using the 834 transaction format to indicate changes in insurance coverage for employees eligible for the LaChoice premium subsidy pursuant to §11311. Such changes shall include but not be limited to: changes in coverage, terminations from coverage and changes to employee demographics.

D. If an employee is to be covered in an employer group by the health insurance issuer and the employee was not included in the initial enrollment roster, the health insurance issuer shall include the employee in a monthly employee update transaction regardless of whether or not the employee is eligible for the LaChoice premium subsidy pursuant to §11311.

E. The health insurance issuer shall provide a monthly report to the Department of Insurance indicating the count of all insured or members covered under LaChoice for each employer group. Such list shall include the following categories:

1. a list of current employers enrolled in the program;

2. the number of insured or members who are receiving the subsidy pursuant to §11311;

3. the number of insured or members who are not receiving the subsidy pursuant to §11311.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2948 (November 2005).

§11309. Underwriting Criteria for Health Insurance Issuer

A. Underwriting criteria shall comply with the provisions in Title 22 and shall be subject to actuarial review and approval by the Department of Insurance, pursuant to R.S. 22:246(6).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2949 (November 2005).

§11311. Criteria for Public Subsidy

A. To be eligible for the LaChoice premium subsidy, an employee of a qualified employer that opts to provide LaChoice must make application and have household income levels at or below 200 percent of the federal poverty level as established by the Department of Health and Hospitals Medicaid Health Insurance Flexibility and Accountability (HIFA) Demonstration Project. Eligibility for the subsidy shall be determined by the Medicaid agency. Implementation of this provision shall be contingent upon the approval of the HIFA demonstration project by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2949 (November 2005).

§11313. Enforcement Provisions

A. The commissioner of insurance shall have the authority to disapprove a policy submitted pursuant to LaChoice in accordance with R.S. 22:621 that fails to comply with the provisions of any statute or regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2949 (November 2005).

§11315. Financial Statement Requirements

A. The following requirement is applicable only to health insurance issuers that offer LaChoice policies. Such health insurance issuers shall be required to report LaChoice business in a supplemental worksheet to the annual statement in a format to be provided by the Louisiana Department of Insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2949 (November 2005).

§11317. Discontinuation of Product Type

A. When a health insurer issuer decides to discontinue offering policies pursuant to the LaChoice program, R.S. 22:250.7(C)(1)(a),(b),(c) and (d) shall be applicable in the discontinuation of such product.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2949 (November 2005).

§11319. Severability

A. If any Section or provision of this regulation or the application to any person or circumstance is held invalid, such invalidity or determination shall not affect other Sections or provisions or the application of this regulation to any persons or circumstances that can be given effect without the invalid Section or provision or application, and for these purposes the Sections and provisions of this regulation and the application to any persons or circumstance are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and 22:245(C)(3) to implement and enforce the following provisions: R.S. 22:244, 22:245, and 22:246, Part VI-B. of Chapter One of Title 22 of the Louisiana Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2949 (November 2005).