

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-combatant 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;