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