

Title 37

INSURANCE

Part III. Patient's Compensation Fund Oversight Board

Editor's Note: Pursuant to the authority and direction of House Concurrent Resolution No. 84 of the 2015 Regular Session, the Louisiana State Law Institute reorganized and recodified Chapter 5 of Title 40. However, all statutory references in the rules below conform to the Chapter 5 numbering scheme as it existed prior to the adoption of HCR No. 84 and the revision authority of the Louisiana State Law Institute.

Chapter 1. General Provisions

§101. Scope

A. The rules of Part III provide for and govern the organization, administration, and defense of the Patient's Compensation Fund (the fund or PCF) by the Louisiana Patient's Compensation Fund Oversight Board (the board), within the Division of Administration; 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:167 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2533 (October 2012).

§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 Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

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

§105. Patient's Compensation Fund: Description

A. The Patient's 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, 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 board 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, establishing surcharge rates or rate changes on the basis of annual actuarial studies, 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:167 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2534 (October 2012).

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

A. These rules are adopted and promulgated to ensure that the Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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 Patient's Compensation Fund Oversight Board established pursuant to R.S. 40:1299.44 .D.

Executive Director—the Executive Director of the Louisiana Patient's Compensation Fund Oversight Board, as

INSURANCE

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 Patient's 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 Patient's Compensation Fund. As long as the financial responsibility requirements for continued qualification in the form prescribed by §§505-509 of these rules, as applicable, 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:168 (February 1992), amended LR 23:68 (January 1997), LR 29:344 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2534 (October 2012).

§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.

Clinical Nurse Specialist—an advanced practice registered nurse educated in a recognized nursing specialty area who is certified according to the requirements of a nationally recognized certifying body and approved by the Louisiana State Board of Nursing, pursuant to R.S. 37:911-935, 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, pursuant to R.S. 37:3240-3257, as amended.

Nurse Practitioner—an advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency and approved by the Louisiana State Board of Nursing, pursuant to R.S. 37:911-935, as amended.

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. 37:1171-1183, 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. 37:2401-2422, 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. 37:2351-2367, 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. 37:911-935, as amended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:168 (February 1992), amended LR 29:344 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2534 (October 2012).

§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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the

Governor, Patient's 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 Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

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

§302. Disability Accommodations

A. A person with a disability is defined as any of the following:

INSURANCE

1. a member of the public or the board with a disability recognized by the ADA; or
2. a designated caregiver of such a person.

B. The written public notice for an open meeting, as required by R.S. 42:19, includes the name, telephone number and email address of a board representative to whom a disability accommodation may be submitted.

C. The requestor shall be provided with an accommodation, including the teleconference number and/or video conference link, for participation via electronic means as soon as possible following receipt of the request, but no later than the start of the scheduled meeting.

D. Participation via electronic means (teleconference or video conference) by a board member who has requested a disability accommodation shall count for purposes of establishing quorum and voting. The presiding officer of the board shall ensure that the voting decision of any member of the board who participates via electronic means is clearly identified, recorded and included in the minutes of the meeting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3) and Act 393 of the 2023 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by Office of the Governor, Patient's Compensation Fund Oversight Board, LR 50:364 (March 2024).

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

A. The position of executive director of the Louisiana Patient's 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 and training in insurance 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. preparation and submission, in conjunction with the PCF's actuary, of the annual actuarial study and indicated surcharge rates and rate changes, to the board;

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

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

amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2535 (October 2012).

§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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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 in the form of a certificate of insurance or policy declaration page 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 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. 22:436 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. 22:481 et seq.; or

INSURANCE

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, any exclusions, and any applicable deductible or uninsured retention. Upon request by the executive director, 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 and timely meets the surcharge payment conditions of §§711-713 of these rules, as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2535 (October 2012).

§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 Patient's 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.1. To maintain financial responsibility for continuing enrollment or qualification with the fund, a self-insured 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 or released pursuant to judicial process.

2. In the event that a self-insured health care provider's deposit provided for by §507 becomes impaired, the executive director shall give written notice of such impairment to the self-insured health care provider, and the self-insured health care provider shall, unless a longer period is provided for by the board, have five days from receipt of such notice to make such additional deposit as will restore the minimum deposit value prescribed by §507. A self-insured health care provider's enrollment with the fund shall terminate on and as

of the later of the last day set by these rules or, if applicable, by the board, if the self-insured health care provider has not on or prior to such date restored the minimum deposit value prescribed by §507. In the case of multiple self-insured health care providers approved by the board to post one deposit, as set forth in §507.B, the enrollment with the fund of each member of the group or each related entity shall terminate on and as of the last day set by these rules or, if applicable, by the board, if the self-insured health care provider has not on or prior to such date restored the minimum deposit value prescribed by §507.

F. A self-insured health care provider shall, within 120 days of receiving notice of a request for review of a malpractice claim, submit a report to the executive director of the anticipated exposure to the fund and the self-insured health care provider and containing sufficient details supporting the anticipated exposure. In addition, said self-insured health care provider shall provide updates to the executive director when significant changes in anticipated exposure occur.

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 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

INSURANCE

the fund shall be terminated.

I. In the event that a health care provider's deposit becomes impaired, he shall have 30 days to make such additional deposit as will restore the minimum deposit value prescribed by §507. A health care provider's enrollment and qualification with the fund for all claims filed against the healthcare provider shall terminate on and as of the last day set by these Rules if the health care provider has not on, or prior to such date, restored the minimum deposit value prescribed by §507. In the case of multiple health care providers, as set forth in §507.B, the enrollment and qualification with the fund of each member of the group or each related entity for all claims filed against any or all of the members of the group or related entity shall terminate on and as of the last day set by these rules if the minimum deposit value prescribed by §507 has not been restored on or prior to such date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2535 (October 2012).

§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 Patient's 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 self-insurance trust 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. Money, accounts, certificates of deposit, or other approved insurance or securities deposited, pledged or assigned to the board pursuant to §509 shall not be assigned, transferred, sold, mortgaged, pledged, hypothecated or otherwise encumbered by the self-insurance trust 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 a member of the self-insurance trust.

D.1. To maintain financial responsibility for continuing enrollment or qualification with the fund, a self-insurance trust shall at all times maintain the unimpaired principal value of the deposit provided for by §509 at not less than \$125,000. The value of the self-insurance trust's deposit shall be deemed impaired when any portion is seized or released pursuant to judicial process.

2. In the event that a self-insurance trust's deposit provided for by §509 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 longer period is provided by the board, have 30 days from receipt of such notice to make such additional deposit as will restore the minimum deposit value prescribed by §509. The enrollment of each member of a self-insurance trust with the fund shall terminate on and as of the last day set by these rules or, if applicable, by the board, if the self-insurance trust has

not on or prior to such date restored the minimum deposit value prescribed by §509.

E. A self-insurance trust shall, within 120 days of one of its members receiving notice of a claim, submit a report of the anticipated exposure to the fund and the self-insurance trust and containing sufficient details supporting the anticipated exposure. In addition, the self-insurance trust shall provide updates to the executive director when significant changes in anticipated exposure occur.

F. 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.

G. 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.

H.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 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 the date on which a self-insurance trust's deposit is withdrawn pursuant to §509, the trust members' enrollment and qualification with the fund shall be terminated.

I. 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 each 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;

J. 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.

K. 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. Upon request by the executive director, 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.

L. 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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2536 (October 2012).

§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

INSURANCE

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. Any such corporation, partnership, limited liability partnership, or limited liability company which fails to provide proof of financial responsibility upon request of the fund after the filing of a request for review of a claim under R.S. 40:1299.47 or after the filing of a lawsuit alleging medical malpractice, shall not be deemed concurrently qualified and enrolled as a health care provider under this Part.

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:173 (February 1992), amended LR 29:345 (March 2003), LR 30:1017 (May 2004), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2538 (October 2012).

§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, and the applicable surcharge.

C. If the executive director determines that an applicant is not eligible for enrollment with the fund, he shall notify the applicant within 15 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 to 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 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.

40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:173 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2538 (October 2012).

§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 available 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2538 (October 2012).

§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 or cancellation of the policy 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, on and as of:

a. the effective date and time of termination, cancellation or impairment of the health care provider's financial responsibility; 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 board or to the self-insurance trust on or before 30 days following the expiration of the prior enrollment

period.

B. Enrollment with the fund must be annually renewed by each enrolled health care provider on or before expiration 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:174 (February 1992), amended LR 29:346 (March 2003), repromulgated LR 29:579 (April 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2538 (October 2012).

§519. Cancellation, Termination of Enrollment

A. A health care provider's enrollment with the fund for all claims filed against the healthcare provider shall be canceled and terminated:

1. as to a health care provider evidencing financial responsibility by certification of insurance pursuant to §505 of these rules, on and as the effective date of cancellation of the health care provider's professional liability insurance coverage;

2. as to a health care provider evidencing financial responsibility pursuant to §§507-509 of these rules, on and as of any date on which:

- a. the health care provider or self-insurance trust, as applicable, ceases to maintain financial responsibility in the amount and form prescribed by these rules; or

- b. the health care provider or self-insurance trust, as applicable, fails, within the allowed time after notice by the executive director, to provide additional security for financial responsibility when existing financial responsibility security is impaired all as provided in §§507-509 of these rules.

3. on any date that the health care provider's professional or institutional license, certification, or registration is suspended or revoked or that the health care provider ceases to be a health care provider as defined by the Act and these rules or otherwise ceases to be eligible for enrollment hereunder.

B. Upon written notice to a health care provider, the executive director may cancel and terminate a health care provider's enrollment with the fund, effective 30 days following the mailing by registered or certified mail, return receipt requested, or giving of such notice in the event that an enrolled health care provider has failed or refused to timely

provide any reports or submit any information or data required to be reported or submitted by these rules, including but not limited to those provided for in §1101. If, within 30 days of receipt of such a notice, a health care provider furnishes to the board any and all delinquent reports, information, and data, as specified by such notice, the health care provider's enrollment with the fund may be continued in effect.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2539 (October 2012).

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 board shall retain a qualified, competent, and independent consulting actuary to advise and consult the board on all aspects of the board's administration, operation, and defense of the fund which require application of the actuarial science. Each year, the board shall cause the consulting actuary to prepare an annual actuarial study required by the Act and these rules. An individual actuary contracted by the board, or a principal actuary assigned to the engagement and employed by a partnership, firm, or corporation contracted by the board, 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 board'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 fund 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, proposed surcharge rates and surcharge rate changes in accordance with the consulting actuary's actuarial analyses, for submission to the board;

5. as requested by the executive director, personal presentation of proposed surcharge rates and surcharge rate changes at meetings of the board; and

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:174 (February 1992), amended LR 29:346 (March 2003), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2557 (November 2010).

§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 board's consulting actuary on the basis of an actuarial analysis of all relevant claims experience data collected and maintained by the board.

B. In the performance of the board's annual actuarial study and the development of a financially sound and appropriate surcharge rate structure for the fund, the board'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 Louisiana Department of Insurance (LDOI) 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 board'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 changes to surcharge rates or to the surcharge rate structure shall be approved by the board when the total assets of the fund could become less than the amount provided for in R.S. 40:1299.44(A)(6)(a) and (b).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 19:204 (February 1993), LR 24:1111 (June 1998), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2557 (November 2010).

§705. Risk Rating

A. Surcharge rates collected by the board 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 board shall be based on the annual average number of occupied beds. Risk classifications and ratings adopted by the board 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 fund's own claims experience, unless the board'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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 29:346 (March 2003), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2557 (November 2010).

§707. Determination of Rates; Notice of Rates

A. The board shall determine surcharge rates in a public meeting held pursuant to Louisiana's open meetings laws based upon actuarial principles and reports, experience and prudent judgment of the board. The board shall provide written or electronic notice of the meeting at least 15 days in advance of the meeting and provide an opportunity for public comment at the meeting before determining surcharge rates.

B. Within 30 days of the date on which the board determines surcharges rates or rate changes, the executive director shall give notice of such rates or rate changes via the board's website and any other means at the discretion of the executive director.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:175 (February 1992), amended LR 24:1112 (June 1998), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2558 (November 2010).

§709. Interim, Emergency Rates

A. Interim or emergency surcharge rates or rate changes may be determined by the board at any time when the board, in consultation with its consulting actuary, determines that a new surcharge rate or rate changes are necessary. The board shall comply with the notice and comment provisions set forth in §707 prior to determining interim or emergency surcharge

rates or rate changes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:176 (February 1992), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2558 (November 2010).

§711. Payment of Surcharges: Insurers and Self-Insurance Trusts

A. Applicable surcharges for enrollment and qualification with the fund shall be collected on behalf of the board by commercial professional health care liability insurance companies and approved self-insurance trusts from insured health care providers electing to enroll and qualify with the fund. Such surcharges shall be collected by such insurers and trusts at the same time and on the same basis as such insurers' and trust's collection of premiums or contributions from such insureds. Surcharges collected by such insurers and trusts on behalf of the board shall be due and payable and remitted to the board by such insurers and trusts within 30 days from the date on which such surcharges are collected from any insured health care provider.

B. Annual surcharges for initial PCF coverage for insured health care providers whose surcharges are collected by insurers and trusts for enrollment and qualification with the fund shall be due and payable to the collecting insurers and trusts on or before the date of initial PCF coverage. Annual surcharges for renewal coverage due the board by insured health care providers whose surcharges are collected by insurers and trusts for enrollment and qualification with the fund shall be due and payable to the collecting insurers and trusts on or before 30 days following the expiration of the prior enrollment period. Remittance of surcharges to the board by the insurers and trusts 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 board shall certify to the board, at the time of remitting such surcharge to the board, 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, agents of the insurer, risk manager, or surplus line agent, and approved self-insurance trust funds to remit payment within 30 days of collecting such annual surcharge may subject the commercial professional liability insurers, commercial insurance underwriters, and approved self-insurance trust funds to a penalty, the amount of which will be set by the board on an annual basis, not to exceed 12 percent of the annual surcharge, and all reasonable attorney 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 all reasonable attorney fees.

D. If the instrument used to pay the surcharge is returned to the board by the payor institution and/or payment hereon is denied for any reason, the health care provider shall be notified thereof by the board. If the surcharge and any insufficient funds (NSF) charge incurred by the board is not paid in full by certified check, cashier's check, money order, or cash equivalent funds received by the board 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 board timely. The timeliness of surcharge remittances to the board 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2558 (November 2010), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2539 (October 2012).

§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. Annual surcharges for initial PCF coverage for self-insured health care providers for enrollment and qualification with the fund shall be due and payable to the board on or before the date of initial PCF coverage. Surcharges due the board by self-insured health care providers for enrollment with the fund for an enrollment year shall be due and payable to the board on or before 30 days following the expiration of the prior enrollment period. Remittance of surcharges to the board 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 board by the payor institution and/or payment hereon is denied for any reason, the health care provider shall be

notified thereof by the board. If the surcharge and any insufficient funds (NSF) charge incurred by the board is not paid in full by certified check, cashier's check, money order, or cash equivalent funds received by the board 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 20:432 (April 1994), LR 23:69 (January 1997), amended by the Division of Administration, Patient's Compensation Fund Oversight Board, LR 36:2559 (November 2010).

§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 most recently approved rate 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 board 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 most recently approve fund surcharge amount 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 board 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 board 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 executive director or board may, at its discretion, waive or defer 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 from the practice of medicine 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 board dies or becomes permanently disabled, then the surcharge to the board for tail coverage for claims occurring during the existence of the fund claims-made coverage shall be considered to have been paid. However, continuous PCF coverage 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 underlying insurance 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 23:69 (January 1997), amended LR 29:347 (March 2003), LR 30:1018 (May 2004), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2539 (October 2012).

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 or by participation in an approved self-insurance

trust pursuant to §509 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 or trust 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, the insurer, agent or trust.

B. A health care provider who qualifies for enrollment with the fund by demonstrating financial responsibility by self-insurance pursuant to §507 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 by the board in accordance with §713 hereof. If such surcharge is not timely collected, the effective date of enrollment with the fund shall be the date on which such surcharge is collected or accepted by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:176 (February 1992), amended LR 23:70 (January 1997), LR 29:347 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2540 (October 2012).

§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 earlier of the date on which the policy period of the insurance policy evidencing such financial responsibility expires or not more than one year from the date on which such health care provider's enrollment became effective.

B. The enrollment of a health care provider qualified for enrollment by evidence of self-insurance pursuant to §507 hereof shall expire not more than 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 not more than one year from the date on which such health care provider's enrollment became effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:177 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2540 (October 2012).

§905. Scope of Coverage: Insureds

A. With respect to health care providers enrolled with the fund by evidence of liability insurance pursuant to §505

hereof, subject to the limitation of liability prescribed by the Act, 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 and subject to the payment of the applicable surcharges.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:177 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2541 (October 2012).

§907. Scope of Coverage: Self-Insureds

A. With respect to health care providers enrolled with the fund by evidence of self-insurance pursuant to §507 hereof, 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 employee individually eligible for enrollment with the fund employed by the health provider when such employed person is not enrolled with the fund. 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:177 (February 1992), amended LR 23:70 (January 1997), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2541 (October 2012).

§909. Scope of Coverage: Self-Insurance Trusts

A. With respect to health care providers enrolled with the fund by evidence of participation in an approved self-insurance trust pursuant to §509 hereof, subject to the limitation of liability prescribed by the Act, 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 and subject to the payment of the applicable surcharges.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the

Governor, Patient's Compensation Fund Oversight Board, LR 18:177 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2541 (October 2012).

Chapter 11. Reporting

§1101. Notice of Claims, Reserves, Proposed Settlement

A. Within 90 days of the date on which a malpractice claim is asserted, or of the date on which a claim that may reasonably impact the fund 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 or medical review panel request. 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 that may reasonably exceed the limitation of liability afforded the health care provider under the Act 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 that has been established and allocated to the claim by the health care provider or insurer. Within 30 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. In any civil action or proceeding in which a health care provider files a dilatory exception of prematurity pursuant to Code of Civil Procedure Article 926(A)(1), said health care provider shall send a copy of the exception and the petition for damages to the board, via certified mail, return receipt requested, concurrently with serving the parties to the civil action or proceeding.

E. Upon filing a petition for damages in court for bodily injuries to or death of a patient on account of medical malpractice, the claimant shall send, by certified mail, return receipt requested, a copy of said petition for damages to the board. The claimant shall also provide written notice to the board of the trial date in such proceeding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:177 (February 1992), amended LR 29:348 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2541 (October 2012).

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

A. On or before August 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 5 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 and enrolled with the fund.

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 April 1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:178 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2542 (October 2012).

§1105. Noncompliance; Failure to Report

A. Noncompliance with the reporting and notice 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. The executive director shall give written notice via certified mail to any health care provider and if applicable, the insurer or trust which, being required to provide reports under these rules, fails to do so within the time specified. The enrollment of a health care provider who does not submit, or have submitted by his insurer, trust or legal representative, the required reports in proper form may 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.

B. Noncompliance with the reporting and notice 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 or self-insurance trust failing or refusing to report as required by these rules. The executive director shall give written notice by certified mail to any self-insured health care provider which, being required to provide reports under these rules, fails to do so within the time specified. The enrollment of a health care provider who does not submit the required reports in proper form may 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:178 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2542 (October 2012).

§1107. Confidentiality

A. All reports, notices, communications, information, records, and data made or given to the executive director, the board or to their agents or contractors pursuant to the provisions of Chapter 11 shall be deemed privileged and confidential by and in the possession of the executive director, the board and/or 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:178 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2542 (October 2012).

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 board 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:178 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2542 (October 2012).

§1303. Fund Accounting

A. The executive director shall be responsible for maintaining accounts and records for the board 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:178 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2542 (October 2012).

§1305. Annual Budget

A. The executive director shall annually project revenue and expense budgets for the fund for the succeeding fiscal year in accordance with the provisions of R.S. 40:1299.44(A)(5)(f). 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 1 to the joint legislative committee on the budget, Senate Judiciary A, House Civil Law and Procedures, Legislative Auditor, Division of Administration and the legislative fiscal office, in accordance with R.S. 40:1299.44(A)(5)(f).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:178 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2543 (October 2012).

§1309. Periodic Reports

A. The executive director shall prepare or cause to be prepared statements of the financial condition of the fund at least quarterly and shall post such reports on the board's website. Such statement may be prepared, at the election of the executive director, in accordance with generally accepted accounting principles relating to accounting for governmental funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR

INSURANCE

18:179 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2543 (October 2012).

§1311. Annual Report

A. Each year, the executive director shall cause to be prepared an annual statement of the financial condition of the fund, which statement shall be in the form of the annual report required to be filed by the Division of Administration and the Legislative Auditor. Such statement shall be submitted to the board, Division of Administration and the legislative auditor. Such statement shall be a public record and posted on the board's website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 19:204 (February 1993), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2543 (October 2012).

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 29:348 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2543 (October 2012).

§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. full name of only one patient for whom, or on whose behalf, the request for review is being filed; however, if the claim involves the care of a pregnant mother and her unborn child, then naming only the mother as the patient shall be sufficient;
3. full name(s) of the claimant(s);
4. full name(s) of defendant health care providers;
5. date(s) of alleged malpractice;
6. brief description of alleged malpractice as to each named defendant; 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;

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;

3. if the malpractice complaint does not contain all of the required information set forth in paragraph (A) of this section, notify the claimant(s) that the malpractice complaint has been received but does not comply with this section and indicate what additional information is required and a reasonable time limit for submitting such additional information; and

4. notify the claimant(s) if verification of employment or renewal of fund coverage must be obtained for a named defendant health care provider for fund qualification to be determined.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 29:348 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2543 (October 2012).

§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.(A)(2)(c). An attorney chairman must be selected within one year from the date the request for review of the claim was filed. If, after one year, 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 selected within 90 days of the certified notice, the board shall dismiss the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 29:348 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2544 (October 2012).

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 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;
8. retaining an appropriately qualified claims manager or principal assistant and delegating to such claims manager those duties and responsibilities as deemed appropriate by the executive director; and
9. the discharge and performance of such other duties, responsibilities, functions, and activities as are delegated by the board.

B. 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 29:348 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2544 (October 2012).

§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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:179 (February 1992), amended LR 29:348 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2544 (October 2012).

§1505. Claim Reserves

A. Within 30 days of receipt of notice of a claim against or potentially involving liability of the fund, the board may 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 board 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:180 (February 1992), amended LR 29:349 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2544 (October 2012).

§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 \$25,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 18:180 (February 1992), amended LR 29:349 (March 2003), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2544 (October 2012).

§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, the Attorney General or his representative, 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor Patient's Compensation Fund Oversight Board, LR 18:180 (February 1992), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2545 (October 2012).

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2545 (October 2012).

§1903. Definitions

Administrative Hearing—hearing held in response to a request or complaint by a patient in need of future medical care or his/her representative, that the fund has failed or refused to pay for medical care or related benefits. The hearing shall be conducted before at least three board members.

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the

Governor, Patient's Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2545 (October 2012).

§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. However, the fund shall not pay for repairs for or replacement of durable medical equipment, vehicles or residential modifications or renovations.

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1888 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2545 (October 2012).

§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 as incurred by the patient and made necessary by the health care provider's malpractice.

B. If a patient's claim for future medical care and related benefits is disputed or payment of the amount thereof has been denied by the board, then the matter may be referred to the board for an administrative hearing.

C.1. The following administrative hearing process shall be followed when such is requested by the claimant or the claimant's representative. The claimant desiring to institute a hearing shall prepare and file with the board a complaint setting forth:

- a. the name and address of each respondent;
- b. a statement, in ordinary and concise language, of the facts upon which the complaint is based, together with supporting evidentiary material, including but not limited to, whenever applicable, particular reference to the statute or statutes, or rules, regulations, and orders that the claimant alleges have been violated.

2. Such complaint will be sent to the general counsel for the board who will contact all parties to determine the date of the hearing. The hearing panel will consist of at least three board members. The parties may provide any evidence they deem necessary and may call witnesses to give testimony that bears upon the issues. A court reporter will be present to record the hearing and to administer the necessary oaths to any witnesses. Each party will be allowed to make a brief opening statement, present evidence and cross-examine any witnesses. The panel members will be allowed to ask questions of both parties and any witnesses. All parties will be allowed to make a closing statement. Following the closing statements, the panel members will meet in private to reach a decision. Findings of fact and decision of the panel will be put in written form and presented to the board in executive session for a final determination and vote. The final decision will be forwarded to the claimant or their representative and the fund's counsel.

3. Should the claimant or their representative disagree with the decision reached through the administrative hearing process, they may file a petition in the 19th judicial district court in accordance with §1931 of these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1889 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2546 (October 2012).

§1909. Attorneys; Medical Experts; Architects; Adjusters

A.1. An attorney chosen to represent the fund pursuant to §1907 shall be an independent contractor, shall meet all applicable requirements for an outside contractor retained by the state of Louisiana, and shall be chosen by the executive director 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, then the attorney

shall be responsible for the matter to the extent of the assignment. The attorney shall issue status reports to the claims adjuster at least every 90 days until the matter is concluded.

3. The attorney chosen to represent the fund may recommend any and all possible remedies to the fund 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. 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. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1566 (December 1993), amended LR 27:1889 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2546 (October 2012).

§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 care and related benefits, or the level of medical care needed, 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,

INSURANCE

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR19:1567 (December 1993), amended LR 27:1889 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2546 (October 2012).

§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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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 care 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, including those for family members providing such care, 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 be less than the federal minimum hourly wage rate as may be revised from time to time regardless of the licensure or qualification of the provider.

2. However, notwithstanding the foregoing, future nursing or sitter care provided 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 beginning in November 2001. However, at no time will the hourly rate paid be below the federal minimum hourly wage rate as may be revised from time to time.

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1567 (December 1993), amended LR 27:1889 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2547 (October 2012).

§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 retain a case manager to develop a treatment protocol for the patient. The patient, or the person legally responsible for 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1568 (December 1993), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2547 (October 2012).

§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 will 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. The fund will fund repairs to the handicap modifications to the vehicle, unless such damage was intentional.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1568 (December 1993), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2547 (October 2012).

§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. In addition,

INSURANCE

all such reimbursements shall be made in accordance with State Travel Regulations in force at the time of the travel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1568 (December 1993), amended LR 27:1889 (November 2001), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2547 (October 2012).

§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. Upon request by the patient and/or the patient's family or care givers for modifications, there will be a meeting with the claims manager to determine specifically what modifications should be made to the home. The claims manager and the architect chosen by the fund will then review the medical report(s), 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 and in accordance with the American with Disabilities Act and other applicable handicap accessibility standards.

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. The fund will determine the amount to be paid by the fund based on the architect's recommendations and proposals obtained from reputable contractors. Any deviations from this amount must be preapproved by the fund or borne by the patient or claimant, as applicable.

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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the

Governor, Patient's Compensation Fund Oversight Board, LR 19:1568 (December 1993), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2548 (October 2012).

§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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

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

§1931. Attorney Fees

A. Following the completion of the administrative hearing process hereunder, 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. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Patient's Compensation Fund Oversight Board, LR 19:1569 (December 1993), amended by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 38:2548 (October 2012).

Chapter 21. Rulemaking Petitions

§2101. Submission of a Rulemaking Petition

A. In accordance with R.S. 49:953(C)(1), any interested person may petition an agency to adopt a new rule, or to amend or repeal an existing rule.

B. To petition the board for changes to the board's current rules, or for the adoption of new rules within the board's purview, an interested person shall submit a written petition to the board. The petition shall include:

1. the petitioner's name and address;
2. the name of the promulgating agency for the rule in question;
3. specific text or a description of the proposed language desired for the adoption or amendment of a rule, or the specific rule and language identified for repeal;
4. justification for the proposed action; and
5. the petitioner's signature.

C. The rulemaking petition shall be submitted by certified mail and addressed to:

Louisiana Patient's Compensation Fund Oversight Board
Attn: Mr. Kenneth H. Schnauder, Executive Director
Iberville Building, 627 North Fourth Street, Suite 2-300
Baton Rouge, LA 70802-5343

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 46:182 (February 2020).

§2103. Consideration of a Rulemaking Petition

A. Upon receipt, a rulemaking petition shall be forwarded to the board for review.

B. Within 90 days of receipt of the rulemaking petition, the board shall either:

1. initiate rulemaking procedures to adopt a new rule, or to amend or repeal an existing rule; or

2. notify the petitioner in writing of the denial to proceed with rulemaking, stating the reason(s) therefor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.4(D)(3), formerly R.S. 40:1299.44(D)(3).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Patient's Compensation Fund Oversight Board, LR 46:182 (February 2020).