PART XXIII. MEDICAL MALPRACTICE

(La. R.S. 40:1299.41 *et seq.*)

§1299.41. Definitions and general applications

A. As used in this Part:

(1) "Ambulance service" means an entity under circumstances in which the provisions of R.S. 40:1299.39 are not applicable which operates either ground or air ambulances, using a minimum of two persons on each ground ambulance, at least one of whom is trained and registered at the level of certified emergency medical technician-basic, or at the intermediate or paramedic levels, or one who is a registered nurse, and using a minimum on any air ambulance of one person trained and registered at the paramedic level or a person who is a registered nurse, or any officer, employee, or agent thereof acting in the course and scope of his employment, including any student enrolled in a qualified emergency medical services educational program under the direct supervision of a licensed health care provider.

(2) "Authority" means the Residual Malpractice Insurance Authority established under Section 1299.46.

(3) "Board" means the Patient's Compensation Fund Oversight Board created in R.S. 40:1299.44(D).

(4) "Claimant" means a patient or representative or any person, including a decedent's estate, seeking or who has sought recovery of damages or future medical care and related benefits under this Part. All persons claiming to have sustained damages as a result of injuries to or death of any one patient are considered a single claimant.

(5) "Claims manager" means the claims manager appointed and employed by the board pursuant to R.S. 1299.44(D)(2)(g).

(6) "Community blood center" means any independent nonprofit nonhospital based facility which collects blood and blood products from donors primarily to supply blood and blood components to other health care facilities.

(7) "Court" means a court of competent jurisdiction and proper venue over the parties.

(8) "Executive director" means the executive director of the board, appointed and employed pursuant to R.S. 40:1299.44(D)(2)(f).

(9) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement, or during or relating to or in connection with the procurement of human blood or blood components.

(10) "Health care provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician, hospital, nursing home, community blood center, tissue bank, dentist, registered or licensed practical nurse or certified nurse assistant, offshore health service provider, ambulance service under circumstances in which the provisions of R.S. 40:1299.39 are not applicable, certified registered nurse anesthetist, nurse midwife, licensed midwife, nurse practitioner, clinical nurse specialist, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, social worker, licensed professional counselor, licensed perfusionist, licensed respiratory therapist, licensed radiologic technologist, licensed clinical laboratory scientist, or any nonprofit facility considered tax-exempt under Section 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, or any professional corporation a health care provider is authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950, or any partnership, limited liability partnership, limited liability company, management company, or corporation whose business is conducted principally by health care providers, or an officer, employee, partner, member, shareholder, or agent thereof acting in the course and scope of his employment.

(11) "Hospital" means any hospital as defined in R.S. 40:2102; any "nursing home" or "home" as defined in R.S. 40:2009.2; or any physician's or dentist's offices or clinics containing facilities for the examination, diagnosis, treatment or care of human illnesses.

(12) "Insurer" means the authority or the entity chosen to manage the authority or an insurer writing policies of malpractice insurance.

(13) "Malpractice" means any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient, including failure to render services timely and the handling of a patient, including loading and unloading of a patient, and also includes all legal responsibility of a health care provider arising from acts or omissions during the procurement of blood or blood components, in the training or supervision of health care providers, or from defects in blood, tissue, transplants, drugs, and medicines, or from defects in or failures of prosthetic devices implanted in or used on or in the person of a patient.

(14) "Offshore health service provider" means any individual or entity which provides any health care service rendered by an emergency medical technician-basic, or at the intermediate or paramedic levels, or one who is a registered nurse, when such medical care is rendered on a fixed platform in Louisiana territorial waters or on the Outer Continental Shelf, adjacent to Louisiana territorial waters, or any instance on the Outer Continental Shelf where the applicable law, under the Outer Continental Shelf Lands Act, 43 U.S.C. 1331 et seq., would be the laws of the state of Louisiana.

(15) "Patient" means a natural person, including a donor of human blood or blood components and a nursing home resident who receives or should have received health care from a licensed health care provider, under contract, expressed or implied.

(16) "Physician" means a person with an unlimited license to practice medicine in this state.

(17) "Proof of financial responsibility" as provided for in this Part shall be determined by the board in accordance with regulations promulgated under the Administrative Procedure Act.

(18) "Representative" means the spouse, parent, guardian, trustee, attorney or other legal agent of the patient.

(19) "Risk" means any health care provider which shall apply for malpractice liability insurance coverage under the provisions of Section 1299.46.

(20) "Risk manager" means an insurance company with no less than an "A" rating according to the then current annual edition of Best's Insurance Reports or a domestic insurance company with assets in excess of ten million dollars chosen by the commissioner according to the public bid laws of the state, to manage the authority.

(21) "Tissue bank" means any independent nonprofit facility procuring and processing human organs or tissues for transplantation, medical education, research, or therapy.

(22) "Tort" means any breach of duty or any negligent act or omission proximately causing injury or damage to another. The standard of care required of every health care provider, except a hospital, in rendering professional services or health care to a patient, shall be to

exercise that degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill.

B. Wherever necessary to the context of this Part the masculine shall mean and include the feminine and the singular shall mean and include the plural.

C. No liability shall be imposed upon any health care provider on the basis of an alleged breach of contract, whether by express or implied warranty, assuring results to be obtained from any procedure undertaken in the course of health care, unless such contract is expressly set forth in writing and signed by such health care provider or by an authorized agent of such health care provider.

D. A health care provider who fails to qualify under this Part is not covered by the provisions of this Part and is subject to liability under the law without regard to the provisions of this Part. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this Part, except as hereinafter provided with respect to the suspension and the running of prescription of actions against a health care provider who has not qualified under this Part when a claim has been filed against the health care provider for review under this Part.

E.(1) Subject to R.S. 40:1299.47, a claimant having a claim under this Part for bodily injuries to or death of a patient on account of malpractice may file a complaint in any court of competent jurisdiction and proper venue. Upon filing the complaint in court for bodily injuries to or death of a patient on account of malpractice, said claimant shall send, by certified mail, return receipt requested, a copy of the complaint, and any amendments thereto, to the board. The claimant shall also promptly provide written notice to the board of the trial date upon receiving notice from the court scheduling a trial in such proceeding.

(2) No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises.

(3) This Section shall not prevent a person from alleging a requisite jurisdictional amount in a malpractice claim filed in a court requiring such an allegation.

(4) All claims and complaints submitted by a patient, claimant, or their representative, as a result of malpractice as defined in this Section, shall, once the parties have certified to the court that discovery is complete, be given priority on the court's docket, to the extent practicable, over any other civil action before the court, provided that the provisions of this Paragraph shall not supersede the provisions of Code of Civil Procedure Article 1573.

F. The provisions of this Part do not apply to any act of malpractice which occurred before September 1, 1975. The provisions of this Part that provide for the suspension and the running of prescription with respect to a health care provider who has not qualified under this Part, but against whom a claim has been filed under this Part, do not apply to any act of malpractice which occurred before September 1, 1981.

G. Notwithstanding the provisions of Subsection D, the running of prescription against a health care provider who is answerable in solido with a qualified health care provider against whom a claim has been filed for review under this Part shall be suspended in accordance with the provisions of R.S. 40:1299.47(A)(2)(a).

H. The provisions of this Part do not apply to any act of malpractice which occurred before September 1, 1975. The provisions of this Part that provide for the suspension of the running of prescription with respect to a health care provider who is answerable in solido with another health care provider apply to an act of malpractice which has been duly submitted for

review prior to September 1, 1981 but in which the third health care provider panelist has not been selected. The provision for the suspension of the running of prescription does not apply to any act of malpractice which has not been duly submitted for review and which has prescribed on September 1, 1981.

I. Nothing in this Part shall be construed to make the patient's compensation fund liable for any sums except for those arising from medical malpractice. Notwithstanding any other law to the contrary, including but not limited to R.S. 13:5106, the provisions of this Part shall not apply to medical malpractice actions against the state or any political subdivision thereof with the exception of a hospital service district and a municipally owned hospital and any entities, organizations, or subsidiary owned, operated, or controlled by such a hospital service district or municipally owned hospital. However, this Part shall apply to any certified emergency medical technician-basic, or at the intermediate or paramedic level, employed by any political subdivision of the state, and to any medical advisor or registered nurse performing emergency medical services under contract with any political subdivision of the state.

J. The board shall appoint legal counsel for the Patient's Compensation Fund. It shall be the responsibility of the board to establish minimum qualifications and standards for lawyers who may be appointed to defend professional liability cases. The minimum qualifications and the appointments procedure shall be published at least annually in the Louisiana Bar Journal or such other publication as will reasonably assure dissemination to the membership of the Louisiana State Bar Association. The primary counsel may be permitted by the board to continue the professional liability litigation on behalf of the Patient's Compensation Fund where no conflict of interest exists or where there is no potential conflict of interest. The function of establishing reserves shall be carried out by the board.

K. The provisions of this Part shall not apply to any health care provider when performing the elective termination of an uncomplicated viable pregnancy.

L. Any cause of action for the unintentional acts or omissions arising from resuscitating a patient who has a declaration concerning life-sustaining procedures executed pursuant to R.S. 40:1299.58.1 et seq., a Louisiana Physician Order for Scope of Treatment executed pursuant to R.S. 40:1299.64.1 et seq., or a do not resuscitate order issued by a physician licensed in this state shall be governed by the provisions of this Part.

Amended by Acts 1991, No. 661, §1; Acts 1991, No. 825, §1; Acts 1992, No. 824, §1; Acts 1992, No. 908, §1; Acts 1997, No. 646, §1; Acts 1999, No. 1309, §8, eff. Jan. 1, 2000; Acts 2001, No. 108, §1; Acts 2001, No. 486, §4, eff. June 21, 2001; Acts 2001, No. 697, §1; Acts 2002, 1st Ex. Sess., No. 86, §1; Acts 2003, No. 431, §1, eff. June 18, 2003; Acts 2003, No. 479, §1; Acts 2003, No. 585, §1; Acts 2003, No. 747, §1; Acts 2004, No. 182, §1; Acts 2006, No. 694, §1; Acts 2008, No. 558, §1; Acts 2009, No. 14, §1; Acts 2010, No. 568, §1; Acts 2010, No. 950, §1; Acts 2012, No. 538, §1, eff. June 5, 2012.

§1299.42. Limitation of recovery

A. To be qualified under the provisions of this Part, a health care provider shall:

(1) Cause to be filed with the board proof of financial responsibility as provided by Subsection E of this Section.

(2) Pay the surcharge assessed by this Part on all health care providers according to R.S. 40:1299.44.

(3) For self-insured health care providers, initial qualification shall be effective upon acceptance of proof of financial responsibility by and payment of the surcharge to the board.

Initial qualification shall be effective for all other health care providers at the time the malpractice insurer accepts payment of the surcharge.

B.(1) The total amount recoverable for all malpractice claims for injuries to or death of a patient, exclusive of future medical care and related benefits as provided in R.S. 40:1299.43, shall not exceed five hundred thousand dollars plus interest and cost.

(2) A health care provider qualified under this Part is not liable for an amount in excess of one hundred thousand dollars plus interest thereon accruing after April 1, 1991, and costs specifically provided for by this Paragraph for all malpractice claims because of injuries to or death of any one patient. The sole cost for which a health care provider qualified under this Part may be assessed by a trial court shall be limited to the cost incurred prior to the rendering of a final judgment against the health care provider, not as a nominal defendant, after a trial on a malpractice claim, including but not limited to, costs assessed pursuant to Code of Civil Procedure Article 970 in any instance where the board was not the offeror or offeree of the proposed settlement amount. The health care provider shall not be assessed costs in any action in which the fund intervenes or the health care provider is a nominal defendant after there has been a settlement between the health care provider and the claimant.

(3)(a) Any amount due from a judgment or settlement or from a final award in an arbitration proceeding which is in excess of the total liability of all liable health care providers, as provided in Paragraph (2) of this Subsection, shall be paid from the patient's compensation fund pursuant to the provisions of R.S. 40:1299.44(C).

(b) The total amounts paid in accordance with Paragraphs (2) and (3) of this Subsection shall not exceed the limitation as provided in Paragraph (1) of this Subsection.

C. Except as provided in R.S. 40:1299.44(C), any advance payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

D.(1) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment.

(2) The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment.

(3) In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs.

(4) In no case shall an advance payment in excess of an award be repayable by the person receiving it.

(5) In the event that a partial settlement is executed between the defendant and/or his insurer with a plaintiff for the sum of one hundred thousand dollars or less, written notice of such settlement shall be sent to the board. Such settlement shall not bar the continuation of the action against the patient's compensation fund for excess sums in which event the court sha1l reduce any judgment to the plaintiff in the amount of malpractice liability insurance in force as provided for in R.S. 40:1299.42(B)(2).

E.(1) Financial responsibility of a health care provider under this Section may be established only by filing with the board proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars per claim with qualification under this Section taking effect and following the same form as the

policy of malpractice liability insurance of the health care provider, or in the event the health care provider is self-insured, proof of financial responsibility by depositing with the board one hundred twenty-five thousand dollars in money or represented by irrevocable letters of credit, federally insured certificates of deposit, bonds, securities, cash values of insurance, or any other security approved by the board. In the event any portion of said amount is seized pursuant to the judicial process, the self-insured health care provider shall have five days to deposit with the board the amounts so seized. The health care provider's failure to timely post said amounts with the board shall terminate his enrollment in the Patient's Compensation Fund.

(2) For the purposes of this Subsection, any group of self-insured health care providers organized to and actually practicing together or otherwise related by ownership, whether as a partnership, professional corporation or otherwise, shall be deemed a single health care provider and shall not be required to post more than one deposit. In the event any portion of the deposit of such a group is seized pursuant to judicial process, such group shall have five days to deposit with the board the amounts so seized. The group's failure to timely post said amounts with the board will terminate its enrollment and the enrollment of its members in the Patient's Compensation Fund.

Added by Acts 1975, No. 817, §1. Amended by Acts 1976, No. 183, §3; Acts 1984, No. 435, §2, eff. July 6, 1984; Acts 1986, No. 499, §1, eff. July 2, 1986; Acts 1990, No. 967, §2, eff. Oct. 1, 1990; Acts 1991, No. 800, §1; Acts 2008, No. 558, §1.

§1299.43. Future medical care and related benefits

A.(1) In all malpractice claims filed with the board which proceed to trial, the jury shall be given a special interrogatory asking if the patient is in need of future medical care and related benefits that will be incurred after the date of the response to the special interrogatory, and the amount thereof.

(2) In actions upon malpractice claims tried by the court, the court's finding shall include a recitation that the patient is or is not in need of future medical care and related benefits that will be incurred after the date of the court's finding and the amount thereof.

(3) If the total amount is for the maximum amount recoverable, exclusive of the value of future medical care and related benefits that will be incurred after the date of the response to the special interrogatory by the jury or the court's finding, the cost of all future medical care and related benefits that will be incurred after the date of the response to the special interrogatory by the jury or the court's finding shall be paid in accordance with R.S. 40:1299.43(C).

(4) If the total amount is for the maximum amount recoverable, including the value of the future medical care and related benefits, the amount of future medical care and related benefits that will be incurred after the date of the response to the special interrogatory by the jury or the court's finding shall be deducted from the total amount and shall be paid from the patient's compensation fund as incurred and presented for payment. The remaining portion of the judgment, including the amount of future medical care and related benefits incurred up to the date of the response to the special interrogatory by the jury or the court's finding shall be paid in accordance with R.S. 40:1299.44(A)(7) and R.S. 40:1299.44(B)(2)(a), (b), and (c).

(5) In all cases where judgment is rendered for a total amount less than the maximum amount recoverable, including any amount awarded on future medical care and related benefits that will be incurred after the date of the response to the special interrogatory by the jury or the court's finding, payment shall be in accordance with R.S. 40:1299.44(A)(7) and R.S. 40:1299.44(B)(2)(a), (b), and (c).

(6) The provisions of this Subsection shall be applicable to all malpractice claims.

B.(1) "Future medical care and related benefits" for the purpose of this Section means all of the following:

(a) 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, incurred after the date of the injury up to the date of the settlement, judgment, or arbitration award.

(b) All reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provisions of such services, after the date of the injury that will be incurred after the date of the settlement, judgment, or arbitration award.

(2) "Future medical care and benefits" as used in this Section shall not be construed to mean non-essential specialty items or devices of convenience.

C. Once a judgment is entered in favor of a patient who is found to be in need of future medical care and related benefits that will be incurred after the date of the response to the special interrogatory by the jury or the court's finding or a settlement is reached between a patient and the patient's compensation fund in which the provision of medical care and related benefits that will be incurred after the date of settlement is agreed upon and continuing as long as medical or surgical attention is reasonably necessary, the patient may make a claim to the patient's compensation fund through the board for all future medical care and related benefits directly or indirectly made necessary by the health care provider's malpractice unless the patient refuses to allow them to be furnished.

D. Payments for medical care and related benefits shall be paid by the patient's compensation fund without regard to the five hundred thousand dollar limitation imposed in R.S. 40:1299.42.

E.(1) The district court from which final judgment issues shall have continuing jurisdiction in cases where medical care and related benefits are determined to be needed by the patient.

(2) The court shall award reasonable attorney fees to the claimant's attorney if the court finds that the patient's compensation fund unreasonably fails to pay for medical care within thirty days after submission of a claim for payment of such benefits.

F. Nothing in this Section shall be construed to prevent a patient and a health care provider and/or the patient's compensation fund from entering into a court-approved settlement agreement whereby medical care and related benefits shall be provided for a limited period of time only or to a limited degree.

G. The patient's compensation fund shall be entitled to have a physical examination of the patient by a physician of the patient's compensation fund's choice from time to time for the purpose of determining the patient's continued need of future medical care and related benefits, subject to the following requirements:

(1)(a) 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 it is intended to conduct the examination.

(b) Such notice must be given at least ten days prior to the time stated in the notice.

(c) Delivery of the notice may be by certified mail.

(2) Such examination shall be by a licensed medical physician or chiropractic physician licensed under the laws of this state or of the state, parish, or county wherein the patient resides.

(3)(a) The place at which such examination is to be conducted shall not involve an unreasonable amount of travel for the patient considering all circumstances.

(b) It shall not be necessary for a patient who resides outside this state to come into this state for such an examination unless so ordered by the court.

(4) Within thirty 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, loss of pay, or other direct expenses.

(5)(a) Examinations may not be required more frequently than at six months intervals except that, upon application to the court having jurisdiction of the claim and after reasonable cause shown therefor, examination within a shorter interval may be ordered.

(b) In considering such application, the court should exercise care to prevent harassment to the patient.

(6)(a) The patient shall be entitled to have a physician or an attorney of his own choice or both present at such examination.

(b) The patient shall pay such physician or attorney himself.

(7) The patient shall be promptly furnished with a copy of the report of the examination made by the physician making the examination on behalf of the patient's compensation fund.

H. If a patient fails or refuses to submit to examination in accordance with a notice and if the requirements of Subsection G of this Section have been satisfied, then the patient shall not be entitled to attorney fees in any action to enforce rights pursuant to Subsection E of this Section.

I.(1) Any physician selected by the patient's compensation fund and paid by the patient's compensation fund who shall make or be present at an examination of the patient conducted in pursuance of this Section may be required to testify as to the conduct thereof and the findings made.

(2) Communications made by the patient upon such examination by such physician or physicians shall not be considered privileged.

J. The patient's compensation fund shall pay all reasonable fees and costs of medical examinations and the costs and the fees of the medical expert witnesses in any proceeding in which the termination of medical care and related benefits is sought.

Acts 1984, No. 435, §3, eff. July 13, 1984; Acts 1990, No. 135, §1, eff. June 29, 1990; Acts 1990, No. 967, §2, eff. Oct. 1, 1990; Acts 2004, No. 181, §1.

§1299.44. Patient's Compensation Fund

A.(1)(a) All funds collected pursuant to the provisions hereof shall be considered self-generated revenues, promptly deposited by the Patient's Compensation Fund Oversight Board into a fund designated as the "Patient's Compensation Fund". The Patient's Compensation Fund Oversight Board is established and authorized pursuant to Subsection D of this Section. Neither the fund nor the board shall be a budget unit of the state. The assets of the fund shall not be state property, subject to appropriation by the legislature, or required to be deposited in the state treasury. The state recognizes and acknowledges that the fund and any income from it are not public monies, but rather are private monies which shall be held in trust as a private custodial fund by the board for the use, benefit, and protection of medical malpractice claimants and the fund's private health care provider members, and all of such funds and income earned from investing the private monies comprising the corpus of this fund shall be subject to use and disposition only as provided by this Section.

(b) The Patient's Compensation Fund Oversight Board may invest, in accordance with R.S. 40:1299.44.1, any portion of the private monies comprising the corpus of the fund, as determined by the board, while maintaining its ability to timely pay claims, future medical care and related benefits, and other current expenses under this Part. The board may enter into a cooperative endeavor agreement whereby the state treasurer may be authorized to invest, in accordance with R.S. 40:1299.44.1, a portion of the private monies comprising the corpus of the fund, as determined by the board.

(c) The fund shall be exempt from participation in and shall not join or contribute financially to or be entitled to the protection of any plan, pool, association, or guaranty fund or insolvency fund.

(d) Neither the fund nor the board may rely on the full faith and credit of this state for payment of legal obligations.

(e) The fund and the board shall not be entitled to an appropriation of state general funds without a specific appropriation approved by the legislature.

(f) Notwithstanding any provision of law to the contrary, in the event the fund is dissolved or liquidated, any remaining balance after all amounts due under this Part to medical malpractice claimants, including future medical care and related benefits as provided in R.S. 40:1299.43, and all amounts due any other person for administrative or operating expenses have been paid from the fund, shall be paid over to the state general fund by the board or then administrator of the fund for deposit in the state treasury.

(2)(a) To provide monies for the fund, an annual surcharge shall be levied on all health care providers in Louisiana qualified under the provisions of this Part.

(b) The board shall cause to be prepared an annual actuarial study of the fund by a qualified competent actuary.

(c) The board and the fund shall be exempt from rate regulation by the commissioner of insurance. The surcharge rates shall be determined by the board in a public meeting held pursuant to the provisions of R.S. 42:11 et seq. based upon actuarial principles and reports, experience, and prudent judgment of the board. The board shall give written or electronic notice of the meeting at least fifteen days in advance and provide an opportunity for public comment at the meeting before determining rates.

(d) The surcharge rates shall not be excessive, inadequate, or unfairly discriminatory. In determining whether surcharge rates are excessive, inadequate, or unfairly discriminatory, consideration may be given to the following items:

(i) Basic rate factors. Due consideration shall be given to past and prospective loss and expense experience, catastrophe hazards and contingencies, events, or trends. Fines and penalties against a health care provider, whether levied by a court or regulatory body, shall not be used by the board or considered in any manner in the loss or expense experience.

(ii) Classification. Risks may be grouped by classification for the establishment of rates. Classification rates may be modified for individual risks in accordance with an experience-rating plan or schedule which apportions a greater percentage of required surcharge increases to those health care providers who generate greater than expected losses.

(iii) Expenses. The expense provisions shall reflect the operating methods of the board and the fund, the past expense experience, and anticipated future expenses.

(iv) Contingencies. The rates may contain a provision for contingencies.

(v) Other relevant factors. Any other factors available at the time of determining the rates.

(e) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager, and surplus line agent.

(f) The board shall collect the surcharge from health care providers qualified as self-insureds.

(g) The surcharge for self-insureds shall be the same amount determined by the board to be the amount of surcharge which the health care provider would reasonably be required to pay were his qualification based upon filing a policy of malpractice liability insurance.

(3)(a) Such surcharge shall be due and payable to the patient's compensation fund within thirty days after the premiums for malpractice liability insurance have been received by the insurer, agent of the insurer, risk manager, or surplus line agent from the health care provider in Louisiana.

(b) It shall be the duty of the insurer, agent of the insurer, risk manager, or surplus line agent to remit the surcharge to the Patient's Compensation Fund within thirty days of the date of payment by the health care provider. Failure of the insurer, agent of the insurer, risk manager, or surplus line agent to remit payment within thirty days may subject the insurer, agent of the insurer, risk manager, or surplus line agent to a penalty, the amount of which will be set by the board on an annual basis, not to exceed a total of twelve percent of the annual surcharge. Upon the failure of the insurer, agent of the insurer, risk manager, or surplus line agent to remit as provided herein, the board is authorized to institute legal proceedings if necessary to collect the surcharge, any penalty amount to be assessed, legal interest, and all reasonable attorney fees.

(4) If the annual surcharge is not paid within the time limited above, upon written notice of such nonpayment given by the board concurrently to the commissioner of insurance and the insurer, risk manager, or surplus line agent, the certificate of authority of the insurer, risk manager, and surplus line agent shall be suspended until the annual surcharge is paid.

(5)(a) All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

(b) The functions of collecting, administering, and protecting the fund, including all matters relating to determining surcharge rates, establishing reserves, the evaluating and settlement of claims, and relating to the defense of the fund, shall be carried out by the board.

(c) The board shall prepare quarterly statements of the financial condition of the fund and publish the statements on the website of the board.

(d) The function of selecting the list of attorney names from which the selection of the attorney chairman of the medical review panels is to be made shall be the responsibility of the office of the clerk of the Louisiana Supreme Court.

(e) These expenses of the board and office of the clerk of the Louisiana Supreme Court shall be paid from the fund in accordance with law.

(f) Not later than the first day of January each year, the board shall submit a copy of its proposed budget for the ensuing fiscal year to the Joint Legislative Committee on the Budget, the House Committee on Civil Law and Procedure, the Senate Committee on Judiciary A, the legislative auditor, and the legislative fiscal office. The format of the budget submission shall be as follows:

(i) A budget message signed by the budget preparer which shall include a summary description of the proposed financial plan, policies, and objectives and assumptions.

(ii) Narrative explanations describing the purpose and functions of the Patient's Compensation Fund.

(iii) Statements for the last completed fiscal year, estimates covering the entire current fiscal year, and projections for the ensuing fiscal year, as follows:

(aa) A statement showing fund balances of the Patient's Compensation Fund at the beginning of each year and at the conclusion of each fiscal year.

(bb) A statement of revenues and receipts, itemized by source.

(cc) Detailed comparative statements of expenditures itemized by source of funds and expenditure category by each major function, program, or service.

(dd) Clearly defined indicators of the quantity and quality of performance of agency functions.

(ee) Participation of agency personnel and board members in state employee benefit programs, including insurance and retirement programs.

(g) Any purchases of furniture, fixtures, equipment, or other property shall be specifically designated, by the method of identification as is reasonable and practical for each item, as the property of the fund.

(h) Repealed by Acts 2002, No. 86, §2.

(6)(a) At all times the fund shall be maintained to provide assets of at least thirty percent of the fund's outstanding liabilities, calculated using the most recent actuarial study and report for the fund.

(b) No reduction in the surcharge shall be made unless such assets are available in the fund.

(7)(a) Claims from the patient's compensation fund exclusive of those provided for in R.S. 40:1299.43 shall be computed at the time the claim becomes final.

(b) A final claim shall be paid within forty-five days of the board's receipt of a certified copy of the settlement, judgment, or arbitration award, unless the fund is exhausted and the proration provision contained in Subparagraph (7)(c) applies.

(c) If the fund would be exhausted by payment in full of all final claims then the amount paid to each claimant shall be prorated.

(d) Any amounts due and unpaid shall be prorated.

(e) Repealed by Acts 2012, No. 802, §2.

B.(1) Subject to the other provisions of this Section, the board shall issue payment in the amount of each claim submitted to and approved by it, or prorated payment, as the case may be, against the fund within thirty days of receipt of a certified copy of the settlement, judgment, or arbitration award except that payment for claims made pursuant to Subparagraph (2)(d) or (e) of this Subsection, or both, shall be made upon receipt of such certified copy.

(2) The only claim against the fund shall be a voucher or other appropriate request by the board after it receives:

(a) A certified copy of a final judgment in excess of one hundred thousand dollars against a health care provider.

(b) A certified copy of a court approved settlement in excess of one hundred thousand dollars against a health care provider.

(c) A certified copy of a final award in excess of one hundred thousand dollars in an arbitration proceeding against a health care provider.

(d) A certified copy of a judgment awarding medical care and related benefits rendered pursuant to R.S. 40:1299.43.

(e) A voucher drawn by the board through the patient's compensation fund defense counsel pursuant to a judgment reciting that a patient is in need of future medical care and related benefits under the provisions of R.S. 40:1299.43.

C. If the insurer of a health care provider or a self-insured health care provider has agreed to settle its liability on a claim against its insured and claimant is demanding an amount in excess thereof from the patient's compensation fund for a complete and final release, then the following procedure must be followed:

(1) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider, if none is pending in the parish where plaintiff or defendant is domiciled seeking (a) approval of an agreed settlement, if any, and/or (b) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition shall be served on the board, the health care provider and his insurer, at least ten days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The board and the insurer of the health care provider or the self-insured health care provider as the case may be, may agree to a settlement with the claimant from the patient's compensation fund, or the board and the insurer of the health care provider or the self-insured health care provider as the case may be, may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty days after the petition is filed.

(4) As soon as practicable after the petition is filed in the court the judge shall fix the date on which the petition seeking approval of the agreed settlement and/or demanding payment of damages from the fund shall be heard, and shall notify the claimant, the insurer of the health care provider or the self-insured health care provider as the case may be, and the board thereof as provided by law.

(5)(a) At the hearing the board, the claimant, and the insurer of the health care provider or the self-insured health care provider, as the case may be, may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the board, the insurer of the health care provider or the self-insured health care provider, as the case may be, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the trier of fact shall determine at a subsequent trial which shall take place only after the board shall have been given an adequate opportunity to conduct discovery, identify and retain expert witnesses, and prepare a defense, the amount of claimant's damages, if any, in excess of the amount already paid by the insurer of the health care provider or self-insured health care provider. The trier of fact shall determine the amount for which the fund is liable and render a finding and judgment accordingly. The board shall have a right to request trial by jury whether or not a jury trial has been requested by the claimant or by any health care provider.

(b) The board shall not be entitled to file a suit or otherwise assert a claim against any qualified health care provider as defined in R.S. 40:1299.41(A) on the basis that the qualified health care provider failed to comply with the appropriate standard of care in treating or failing to treat any patient.

(c) The board may apply the provisions of Civil Code Article 2323 or 2324, or both, to assert a credit or offset for the allocated percentage of negligence or fault of a qualified health care provider provided at least one of the following conditions is met:

(i) A payment has been made to the claimant by, in the name of, or on behalf of the qualified health care provider whose percentage of fault the board seeks to allocate.

(ii) A payment has been made to the claimant by, in the name of, or on behalf of another qualified health care provider in order to obtain a dismissal or release of liability of the qualified health care provider whose percentage of fault the board seeks to allocate, provided that there shall be no separate credit or offset for the fault of an employer or other vicariously liable entity who was not independently negligent or otherwise at fault and who makes a payment in order to obtain a dismissal or release of liability of a single qualified health care provider for whom the payor is vicariously liable.

(iii) All or a portion of a payment made by another qualified health care provider, by the insurer of another qualified health care provider, or by the employer of another qualified health care provider has been attributed to or allocated to the qualified health care provider whose percentage of fault the board seeks to allocate, provided that there shall be no separate credit or offset for the fault of an employer or other vicariously liable entity who was not independently negligent or otherwise at fault and who makes a payment in order to obtain a dismissal or release of liability of a single qualified health care provider for whom the payor is vicariously liable.

(iv) A medical review panel has determined that the qualified health care provider whose percentage of fault the board seeks to allocate failed to comply with the appropriate standard of care and that the failure was a cause of the damage or injury suffered by the patient, or a medical review panel has determined that there is a material issue of fact, not requiring expert opinion, bearing on liability of the qualified health care provider whose percentage of fault the board seeks to allocate for consideration by the trier of fact.

(v) The qualified health care provider does not object within thirty days after notice of the board's intention to allocate the health care provider's percentage of fault is delivered via certified mail to the plaintiff, the qualified health care provider, and the qualified health care provider's professional liability insurer or to their attorneys.

(vi) The court determines, after a hearing in which the qualified health care provider whose percentage of fault the board seeks to allocate shall be given an opportunity to appear and participate, that there has been collusion or other improper conduct between the defendant health care providers to the detriment of the interests of the fund.

(d) Except where the sum of one hundred thousand dollars has been paid by, in the name of, or on behalf of the qualified health care provider whose percentage of fault the board seeks to allocate, in any case in which the board is entitled pursuant to the provisions of Civil Code Article 2323 or 2324, or both, to assert a credit or offset for the allocated percentage of negligence or fault of a qualified health care provider, the board shall have the burden of proving the negligence or fault of the qualified health care provider whose percentage of fault the board seeks to allocate.

(e) In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the trier of fact shall consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of one hundred thousand dollars, or where the self-insured health care provider has paid one hundred thousand dollars.

(f) In each instance in which a claimant seeks to recover any sum from the board, each qualified health care provider or insurer or employer of a qualified health care provider who has made or has agreed to make any payment, including any reimbursement of court costs, medical expenses, or other expenses, to the claimant, the claimant's attorney, or any other person or entity

shall be required, not later than ten days after the filing of the petition for approval of the settlement, to file and serve upon the board an answer to the petition for approval of the settlement which sets forth a complete explanation of each such payment, to include the identity of each payee, the identity of each entity by or on whose behalf each payment has been or is to be made, each amount paid or to be paid directly or indirectly by, on behalf of, or which has been or is to be attributed or allocated to any qualified health care provider, the purpose of each such payment, and the precise nature of any collateral agreement which has been made or is to be made in connection with the proposed settlement.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil court case tried by the court.

(7) For the benefit of both the insured and the patient's compensation fund, the insurer of the health provider shall exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof. A self-insured health care provider shall, for the benefit of the patient's compensation fund, also exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof.

(8) The parties may agree that any amounts due from the patient's compensation fund pursuant to R.S. 40:1299.44(B) be paid by annuity contract purchased by the patient's compensation fund for and on behalf of the claimant.

(9) Notwithstanding any other provision of this Part, any self-insured health care provider who has agreed to settle its liability on a claim and has been released by the claimant for such claim or any other claim arising from the same cause of action shall be removed as a party to the petition, and his name shall be removed from any judgment that is rendered in the proceeding. Such release shall be filed with the clerk of court in the parish in which the petition is filed upon the filing of a properly executed, sworn release and settlement of claim.

D.(1)(a) The Patient's Compensation Fund Oversight Board is hereby created and established in the office of the governor, division of administration. The board shall be comprised of nine members, appointed by the governor subject to Senate confirmation.

(b) Nine members of the board shall be a representative of and for one or more classes of health care providers enrolled in the fund, and the board's membership shall be apportioned according to the distribution of aggregate surcharges paid to the fund among the several classes of health care providers enrolled with the fund, as follows:

(i) Four members of the board shall be representatives of the class of health care providers contributing the greatest percentage of the fund's aggregate surcharges.

(ii) Two members of the board shall be representatives of the class of health care providers contributing the second greatest percentage of the fund's aggregate surcharges.

(iii) One member of the board shall be a representative of the class of health care providers contributing the third greatest percentage of the fund's aggregate surcharges.

(iv) One member of the board shall be appointed to represent all other classes of health care providers enrolled with the fund.

(c) The ninth member of the board shall be appointed from nominees provided by the principal professional insurance agents organizations and this member shall be familiar with property and casualty insurance and licensed in this state as a producer.

(d) Appointments of members representing a single class of health care providers shall be made from nominations solicited from the respective principal professional organizations of

such health care providers in the state. The member of the board representing all other classes of health care providers shall be nominated by concurrence of the respective principal professional organizations of such health care providers in the state. In the absence of such concurrence each such professional organization shall name a representative to an ad hoc committee which shall, from among its number, nominate a representative to the board.

(e) For the purpose of apportioning representation on the board, the percentage surcharge contribution of each distinct class of health care providers listed by R.S. 40:1299.41 to the aggregate surcharges paid to the fund shall be calculated for each fiscal year of the fund, and apportionment with respect to an initial or subsequent appointment to the board shall be based on such percentage contributions for the fund fiscal year preceding any such appointment.

(f) Two of the initial members of the board appointed pursuant to Item (1)(b)(i) of this Subsection, one of the initial members appointed pursuant to Item (1)(b)(ii), and the member appointed pursuant to Item (1)(b)(iii) shall serve for terms of three years. One of the members of the initial board appointed pursuant to Item (1)(b)(i) of this Subsection and one of the initial members appointed pursuant to Item (1)(b)(ii) shall serve for terms of two years. The remaining members of the initial board shall serve for terms of one year. Thereafter, each member of the board shall serve for a term of three years, with any vacancy occurring in any such position being filled for the unexpired term of such position in the manner of the original appointment, in accordance with the apportionment of representation provided for by this Subsection.

(g) The board shall annually elect a chairman and secretary from among its members and shall meet not less frequently than quarterly during the calendar year on the call of the chairman at such times and places as he may designate.

(h) The members of the board shall receive seventy-five dollars per day while engaged in board business and for attendance at all meetings of the board. Reasonable expenses incurred by board members in their travel to and attendance at meetings of the board shall be reimbursed by the fund in accordance with applicable laws and administrative regulations. The members of the board shall not be reimbursed for any expenses incurred for board meetings outside of the state.

(2)(a) The board shall be responsible, and have full authority under law, for the management, administration, operation and defense of the fund in accordance with the provisions of this Part.

(b) In addition to other powers and authority expressly or impliedly conferred on the board by this Part, the board shall have the authority, to the extent not inconsistent with the provisions of this Part, to:

(i) Collect all surcharges and other monies due the fund.

(ii) Establish and define the standards and forms of financial responsibility required of self-insured health care providers, and the standards and forms of malpractice liability insurance policies issued by admitted insurance companies and the standards, forms, acceptable ratings and other criteria for medical malpractice liability insurance policies issued by non-admitted insurance companies which are acceptable as proof of financial responsibility pursuant to R.S. 40:1299.42, as a condition to initial and continuing enrollment with the fund.

(iii) Collect, accumulate, and maintain claims experience data from enrolled health care providers and insurance companies providing professional liability insurance coverage to health care providers in this state, in the form necessary or appropriate to permit the board to determine appropriate surcharge rates for the fund.

(iv) Employ, or in accordance with the provisions of law applicable to contracting for personal, professional or consulting services, retain the services of a qualified competent actuary

to perform the annual actuarial study of the fund required by this Section and to advise the board on all aspects of the fund's administration, operation and defense which require application of the actuarial science.

(v) Contract for any services necessary or advisable to implement the authority and discharge the responsibilities conferred and imposed on the board by this Part.

(vi) Employ, in the unclassified service, an appropriately qualified executive director and delegate to such executive director all or any portion of the authority for administration and operation of the fund vested in the board, subject to the superseding authority of the board.

(vii) Employ, in the unclassified service, an appropriately qualified claims manager and delegate to such claims manager all or any portion of the authority for the protection and defense of the fund vested in the board, subject to the superseding authority of the board.

(viii) Employ, or contract with, legal counsel to advise and represent the board and represent the fund in proceedings pursuant to this Part.

(ix) Employ such clerical personnel as may be necessary or appropriate to carry out the responsibilities of the board under this Part.

(x) Defend the fund from all claims due wholly or in part to the negligence or liability of anyone other than a qualified health care provider regardless of whether a qualified health care provider has settled and paid its statutory maximum or has been adjudged liable or negligent.

(xi) Defend the fund from all claims arising under R.S. 40:1299.44(D)(2)(b)(x) and obtain indemnity and reimbursement to the fund of all amounts for which anyone other than a qualified health care provider may be held liable. The right of indemnity and reimbursement to the fund shall be limited to that amount that the fund may be cast in judgment.

(xii) Intervene as a matter of right, at its discretion, in any civil action or proceeding in which the constitutionality of this Part, R.S. 9:5628, R.S. 9:5628.1 or any other Louisiana law related to medical malpractice as defined in this Part is challenged.

(xiii) The right to apply the provisions of Civil Code Article 2323 or 2324, or both, to assert a credit or offset for the allocated percentage of negligence or fault of a qualified health care provider shall be governed by the provisions of Subparagraph (C)(5)(c) of this Section.

(xiv) Intervene as a matter of right, at its discretion, 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) and the board reasonably believes either of the following:

(aa) Any health care provider is not qualified under this Part.

(bb) Any claim is not subject to this Part.

Any intervention and participation by the board in any civil action or proceeding pursuant to this Subparagraph shall be strictly limited to the health care provider's qualification status under this Part and whether the claim is subject to this Part. A copy of the exception and the petition for damages shall be sent by the health care provider filing the dilatory exception of prematurity to the board, via certified mail, return receipt requested, concurrently with serving the parties to the civil action or proceeding.

(xv) Intervene as a matter of right, at its discretion, in any civil action or proceeding involving malpractice as defined in R.S. 40:1299.41 in which either of the following occurs:

(aa) A self-insured health care provider is the subject of a liquidation, insolvency, receivership, or bankruptcy proceeding.

(bb) A health care provider's insurer is the subject of a liquidation, insolvency, receivership, or bankruptcy proceeding, the insurer has been discharged from the civil action or

proceeding and the malpractice claim is not covered by the Louisiana Insurance Guaranty Association.

(xvi) Employ an appropriately qualified chief investment officer and delegate to him a portion of the authority vested in the board related to investments, subject to the superseding authority of the board.

(3) The board shall have authority, in accordance with applicable provisions of the Administrative Procedure Act, to adopt and promulgate such rules, regulations and standards as it may deem necessary or advisable to implement the authority and discharge the responsibilities conferred and imposed on the board by this Part.

(4) All communications made and all documents and records developed by, between or among the attorney general, claims manager, the oversight board, any person or entity contracted to provide services to or on behalf of the fund under this Part, and enrolled health care providers and their insurers, relative to or in anticipation of defense of the fund or enrolled health care providers against, establishment of reserves with respect to, or prospective settlement of, individual malpractice claims shall be confidential and privileged against disclosure to any third party, pursuant to request, subpoena, or otherwise.

(5) Any meeting of the board or any portion of any meeting of the board which is restricted to consideration of and/or action upon pending or threatened claims against the fund or health care providers with the fund shall not be subject to the provisions of R.S. 42:11 through 28.

E. In any instance in which a complaint for bodily injuries to or death of a patient on account of malpractice has been filed in court and the parties enter into a stipulation prior to trial as to the amount of past medical expenses and related benefits and the amount exceeds one hundred thousand dollars, the parties shall also stipulate to the admissibility of the documents supporting the stipulated amount and shall introduce these documents into evidence at the trial for which the stipulation was entered into.

Added by Acts 1975, No. 817, §1. Amended by Acts 1976, No. 183, §4; Acts 1977, No. 261, §2; Acts 1979, No. 298, §1, eff. July 10, 1979; Acts 1984, No. 41, §1, eff. June 5, 1984; Acts 1984, No. 435, §4, eff. July 6, 1984; Acts 1986, No. 500, §1; Acts 1986, No. 636, §1; Acts 1988, No. 507, §1; Acts 1990, No. 967, §2, eff. Oct. 1, 1990; Acts 1991, No. 668, §1; Acts 1991, No. 800, §1; Acts 1995, No. 1258, §1; Acts 2001, No. 526, §1; Acts 2001, No. 725, §1, eff. June 25, 2001; Acts 2002, 1st Ex. Sess., No. 86, §§1, 2; Acts 2003, No. 431, §1, eff. June 18, 2003; Acts 2003, No. 882, §1, eff. July 1, 2003; Acts 2004, No. 309, §1; Acts 2007, No. 459, §4, eff. Jan. 1, 2008; Acts 2008, No. 558, §1; Acts 2010, No. 78, §1; Acts 2010, No. 411, §§1, 2, eff. July 1, 2010; Acts 2011, No. 160, §1; Acts 2011, No. 263, §1; Acts 2012, No. 802, §§1, 2; Acts 2013, No. 80, §§1-3.

§1299.44.1. Investment responsibilities

A. The Patient's Compensation Fund shall be maintained for the use, benefit, and protection of medical malpractice claimants and private health care provider members of the fund. The fund shall be maintained on a sound actuarial basis and the investment practices of the board in administering the fund are an integral part.

B. The prudent man rule shall be applied by the board in investing monies of the fund.

C.(1) The prudent man rule shall require each member of the board and the board collectively to act with the care, skill, prudence, and diligence under the circumstances prevailing

that a prudent institutional investor acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

(2) The prudent man standard requires the exercise of reasonable care, skill, and caution, and is to be applied to investments not in isolation, but in the context of the fund portfolio, and as part of an overall investment strategy, which shall include an asset allocation study and plan for implementation thereof, incorporating risk and return objectives reasonably suited to the fund. The asset allocation study and implementation plan shall include the examination of market value risk, credit risk, interest rate risk, inflation risk, counterparty risk, and concentration risk. The investment policy of the board shall preserve and enhance principal over the long term and provide adequate liquidity and cash flow for the payment of benefits and expenses of the fund and the board under this Part. The investments shall be diversified to minimize the risk of significant losses unless it is clearly prudent to do otherwise.

D.(1) Notwithstanding the prudent man rule, the board shall not invest more than twenty-five percent of the total portfolio in equities, except as provided in Paragraph (2) of this Subsection.

(2) The board may invest more than twenty-five percent of the total portfolio in equities, so long as not more than thirty-five percent of the total portfolio is invested in equities and at least ten percent of the total equity portfolio is invested in one or more index funds which seek to replicate the performance of the chosen indices.

(3) When contemplating any investment, action, or asset allocation, the following factors shall be considered:

(a) The availability of public pricing to value each investment.

(b) The ability to liquidate each investment at a fair market price within a reasonable time for the size of investment being considered.

(c) The degree of transparency that accompanies each investment.

(d) The risk of fluctuations in currency.

(e) The experience of the professionals who will manage each investment and the financial soundness of the business entity employing the professionals.

(f) The degree of diversification within each investment and what each may provide relative to the existing investments.

(g) Whatever leverage is involved.

(h) The jurisdiction of the laws that govern each investment.

(i) The net return expected relative to the risk associated with each investment.

E.(1) The board shall electronically submit semiannual reports beginning January 1, 2012, to the House Committee on Civil Law and Procedure and the Senate Committee on Judiciary A. The reports shall be submitted no later than thirty calendar days after January first and July first of each year and shall contain the following:

(a) The investment return net of investment fees and expenses expressed as a percentage return and dollar amount.

(b) The amount of administrative expenses.

(c) The board approved target asset allocation.

(d) The current actual asset allocation of the portfolio.

(2) Investment returns reported in accordance with this Subsection shall be by total fund and particular asset class over the six-month period reported, fiscal year-to-date, one-year, three-year, five-year, and ten-year periods.

F. The board is hereby authorized, in requesting proposals for investment advisory services, to require fees to be quoted as a fixed fee, a fee based on market value of assets, or a performance fee.

G.(1) Investment performance reports shall be in compliance with the current Performance Presentation Standards as amended and published by the Association for Investment Management and Research or any successor entity.

(2) Investment performance composite data submitted in response to a request for proposal or any other solicitation or selection process used by the board for hiring an investment manager or investment advisor shall be in compliance with the current Performance Presentation Standards as amended and published by the Association for Investment Management and Research or any successor entity.

(3) The board shall require, at least annually, the investment managers or investment advisors employed or otherwise retained by the board to submit investment performance composite data that is subject to a Level I verification as defined in the Performance Presentation Standards as amended and published by the Association for Investment Management and Research or any successor entity.

H.(1) Consultants and money managers shall provide full disclosure of conflicts of interest to the board. Consultants shall also provide full disclosure of any payments received from money managers, in hard or soft dollars, for any services provided, including but not limited to performance measurement, business consulting, and education.

(2) Each consultant and money manager shall submit a written disclosure report semiannually to the board beginning January 1, 2012. A report shall be submitted regardless of whether the consultant or money manager has any conflict or payment to report. If a reportable agreement is confected during any reporting period, the consultant or money manager shall notify the board of the agreement within seven business days.

I. Any consultant or money manager found to be in violation of Subsection H of this Section shall pay to the board an amount of money equal to the value of the undisclosed revenue or payment and any damages caused by the failure to disclose. Additionally, if the consultant or money manager intentionally failed to disclose as required in Subsection H of this Section, he shall pay to the board an amount equal to three times the value of the revenue or payment he failed to disclose as a penalty and any damages caused by the failure to disclose.

Acts 2011, No. 160, §1.

§1299.45. Malpractice coverage

A.(1) Only while malpractice liability insurance remains in force, or in the case of a self-insured health care provider, only while the security required by regulations of the board remains undiminished, are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this Part.

(2) 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 this Part, and who is providing health care on behalf of such corporation, partnership, or limited liability company, is qualified as a health care provider under the provisions of R.S. 40:1299.42(A), such corporation, partnership, limited liability partnership, or limited liability company shall, without the payment of an additional surcharge, be deemed concurrently qualified and enrolled as a health care provider under this Part. 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 filing of proof of financial responsibility with the board shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this Part.

C. Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this Part is void, except that a provision in a malpractice liability insurance policy approved by the board which limits the aggregate sum for which the insurer may be liable during the policy period shall be valid.

D. Every policy issued under this Part is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the legislature of the state of Louisiana as fully as if it were written therein:

(1) The insurer assumes all obligations to pay an award imposed against its insured under the provisions of this Part; and

(2) Any termination of this policy by cancellation is not effective as to patients claiming against the insured covered hereby, unless at least thirty days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the board at their offices. In no event shall said cancellation affect in any manner any claim which arose against the insurer or its insured during the life of the policy.

E. If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails, or refuses to comply with any provisions of this Part, in addition to any other legal remedy, the board may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this Part and has resubmitted its policy form and received the approval of the board.

Added by Acts 1975, No. 817, §1. Amended by Acts 1976, No. 183, §5; Acts 1978, No. 413, §1; Acts 1986, No. 208, §1; Acts 1986, No. 498, §1; Acts 1990, No. 967, §2, eff. Oct. 1, 1990; Acts 1997, No. 646, §1; Acts 2004, No. 309, §1.

§1299.46. Risk management; authority

A. The purpose of this Section is to make malpractice liability insurance available to qualified risks as defined in this Part.

B. There is created the Residual Malpractice Insurance Authority. The authority is empowered to engage in making malpractice liability insurance available in this state. Governance and administration of the authority shall be vested with the board.

C.(1) The board shall choose a risk manager for the authority according to the public bid laws of the state.

(2) Unless otherwise agreed between the risk manager and the board, the separate, personal or independent assets of the risk manager shall not be liable for or subject to use or expenditure for the purpose of providing insurance by the authority.

(3) All contracts between the authority and the risk manager, and any amendment thereto, and any adjustments made by the board in the compensation or duties of the risk manager permitted by such contracts shall require the approval of the division of administration.

D. In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

(1) Be subject to all laws and regulations of this state which apply to insurance. Except as provided by this Part the Residual Malpractice Insurance Authority shall not be subject to the taxes provided by the Louisiana Insurance Code.

(2) Prepare and file appropriate forms with the Department of Insurance.

(3) Prepare and file premium rates with the Department of Insurance.

(4) Perform the underwriting functions; and subject to the approval of the board, shall formulate underwriting standards for insuring health care providers who by reason of training, experience, claims history and other generally accepted underwriting standards are reasonable insurance risks.

(5) Dispose of all claims and litigations arising out of insurance policies.

(6) Maintain complete books and records.

(7) File an annual financial statement regarding its operations under this Section with the Department of Insurance on forms prescribed by the commissioner.

(8) Obtain private reinsurance for the authority, if necessary.

(9) Prepare and file for approval of the commissioner, a schedule of agent's compensation.

(10) Prepare and file a plan of operations with the commissioner for approval.

E. Unless otherwise agreed between the risk manager and the board, the risk manager shall receive as compensation for its services only a percentage of all premiums received by it under the terms of this Section, as determined by the board and approved by the division of administration.

F. If a health care provider desires malpractice liability insurance under this Part, he shall forward his application to the risk manager. The risk manager shall not consider any application unless a health care provider furnishes in his application evidence of his having either been refused coverage by at least two private insurers writing medical malpractice insurance in the state, or having been refused coverage by the only private insurer writing medical malpractice insurance in the state, or that no private insurer is writing such insurance in the state. Upon written application therefor, the risk manager shall provide a malpractice liability insurance binder to a health care provider who has applied for medical malpractice insurance to any private insurer writing medical malpractice insurance in the state. Such binder shall remain in effect for no more than sixty days from the date of the application by the health care provider to such private insurer. Upon proof by the health care provider submitted to the risk manager that he has not been accepted by any private insurer during the sixty day period, the risk manager shall assume that the health care provider has been rejected for private insurance coverage. In that case, the risk manager shall, if the health care provider meets the underwriting standards called for in Paragraph (4) of Subsection D of this Section, issue a policy of insurance to the health care provider. If within the sixty day period the applicant is accepted by a private insurer, the binder shall expire at the time of such acceptance.

G. If the risk manager declines to accept the risk, notice of declination, together with reasons, shall be sent to the applicant and the board. The applicant shall have ten days from the date of notice to file an appeal for review by the board. On appeal, the board shall review the decision of the risk manager to determine whether the approved underwriting standards have been fairly applied by the risk manager and shall enter an appropriate order.

H. The surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the risk manager with the concurrence of the board in accordance with the insurance code of the state of Louisiana and investment income generated shall remain in the fund. These funds shall not be considered public or state funds.

I. The authority may issue malpractice liability insurance policies only to health care providers who are residents of Louisiana and to corporations, foreign or domestic, with regard to health care facilities operated within Louisiana. Insofar as practicable, only the claims experience of Louisiana health care providers shall be considered in the determination of rates for such policies. The rates for such policies shall otherwise be determined and approved according to the same procedures and principles as rates for malpractice liability policies issued by private insurers in Louisiana. The rates for such policies shall be at least equal to the highest rate established for any particular category of malpractice liability insurance of a like policy issued by private insurers in the state.

J. The state of Louisiana assumes no liability for medical malpractice insurance policies written by the authority. Every policy issued by the authority shall contain a statement that the authority's liability or the liability of the policy is limited to the authority's reserves.

Added by Acts 1975, No. 817, §1. Amended by Acts 1976, No. 183, §6; 1977, No. 261, §3; Acts 1990, No. 967, §2, eff. Oct. 1, 1990.

A.(1)(a) **§1299.47. Medical review panel**

All malpractice claims against health care providers covered by this Part, other than claims validly agreed for submission to a lawfully binding arbitration procedure, shall be reviewed by a medical review panel established as hereinafter provided for in this Section. The filing of a request for review by a medical review panel as provided for in this Section shall not be reportable by any health care provider, the Louisiana Patient's Compensation Fund, or any other entity to the Louisiana State Board of Medical Examiners, to any licensing authority, committee, or board of any other state, or to any credentialing or similar agency, committee, or board of any clinic, hospital, health insurer, or managed care company.

(b) A request for review of a malpractice claim or a malpractice complaint shall contain, at a minimum, all of the following:

(i) A request for the formation of a medical review panel.

(ii) The 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 the mother as the patient shall be sufficient.

(iii) The names of the claimants.

(iv) The names of the defendant health care providers.

(v) The dates of the alleged malpractice.

(vi) A brief description of the alleged malpractice as to each named defendant health care provider.

(vii) A brief description of the alleged injuries.

(c) A claimant shall have forty-five days from the mailing date of the confirmation of receipt of the request for review in accordance with Subparagraph (3)(a) of this Subsection to pay to the board a filing fee in the amount of one hundred dollars per named defendant qualified under this Part.

(d) Such filing fee may be waived only upon receipt of one of the following:

(i) An affidavit of a physician holding a valid and unrestricted license to practice his specialty in the state of his residence certifying that adequate medical records have been obtained and reviewed and that the allegations of malpractice against each defendant health care provider named in the claim constitute a claim of a breach of the applicable standard of care as to each named defendant health care provider.

(ii) An in forma pauperis ruling issued in accordance with Louisiana Code of Civil Procedure Article 5181 et seq. by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process.

(e) Failure to comply with the provisions of Subparagraph (c) or (d) of this Paragraph within the specified forty-five day time frame in Subparagraph (c) of this Paragraph shall render the request for review of a malpractice claim invalid and without effect. Such an invalid request for review of a malpractice claim shall not suspend time within which suit must be instituted in Subparagraph (2)(a) of this Subsection.

(f) All funds generated by such filing fees shall be private monies and shall be applied to the costs of the Patient's Compensation Fund Oversight Board incurred in the administration of claims.

(g) The filing fee of one hundred dollars per named defendant qualified under this Part shall be applicable in the event that a claimant identifies additional qualified health care providers as defendants. The filing fee applicable to each identified qualified health care provider shall be due forty-five days from the mailing date of the confirmation of receipt of the request for review for the additional named defendants in accordance with R.S. 40:1299.47(A)(3)(a).

(2)(a) The filing of the request for a review of a claim shall suspend the time within which suit must be instituted, in accordance with this Part, until ninety days following notification, by certified mail, as provided in Subsection J of this Section, to the claimant or his attorney of the issuance of the opinion by the medical review panel, in the case of those health care providers covered by this Part, or in the case of a health care provider against whom a claim has been filed under the provisions of this Part, but who has not qualified under this Part, until ninety days following notification by certified mail to the claimant or his attorney by the board that the health care provider is not covered by this Part. The filing of a request for review of a claim shall suspend the running of prescription against all joint and solidary obligors, and all joint tortfeasors, including but not limited to health care providers, both qualified and not qualified, to the same extent that prescription is suspended against the party or parties that are the subject of the request for review. Filing a request for review of a malpractice claim as required by this Section with any agency or entity other than the division of administration shall not suspend or interrupt the running of prescription. All requests for review of a malpractice claim identifying additional health care providers shall also be filed with the division of administration.

(b) The request for review of a malpractice claim under this Section shall be deemed filed on the date of receipt of the request stamped and certified by the division of administration or on the date of mailing of the request if mailed to the division of administration by certified or registered mail only upon timely compliance with the provisions of Subparagraph (1)(c) or (d) of this Subsection. Upon receipt of any request, the division of administration shall forward a copy of the request to the board within five days of receipt.

(c) An attorney chairman for the medical review panel shall be appointed within one year from the date the request for review of the claim was filed. Upon appointment of the attorney chairman, the parties shall notify the board of the name and address of the attorney chairman. If the board has not received notice of the appointment of an attorney chairman within nine months from the date the request for review of the claim was filed, then the board shall send notice to the parties by certified or registered mail that the claim will be dismissed in ninety days unless an attorney chairman is appointed within one year from the date the request for review of the claim was filed. If the board has not received notice of the appointment of an attorney chairman within one year from the date the request for review of the claim was filed, then the board shall promptly send notice to the parties by certified or registered mail that the claim has been dismissed for failure to appoint an attorney chairman and the parties shall be deemed to have waived the use of the medical review panel. The filing of a request for a medical review panel shall suspend the time within which suit must be filed until ninety days after the claim has been dismissed in accordance with this Section.

(3) It shall be the duty of the board within fifteen days of the receipt of the claim by the board to:

(a) Confirm to the claimant by certified mail, return receipt requested, that the filing has been officially received and whether or not the named defendant or defendants have qualified under this Part.

(b) In the confirmation to the claimant pursuant to Subparagraph (a) of this Paragraph, notify the claimant of the amount of the filing fee due and the time frame within which such fee is due to the board, and that upon failure to comply with the provisions of Subparagraph (1)(c) or (d) of this Subsection, the request for review of a malpractice claim is invalid and without effect and that the request shall not suspend the time within which suit must be instituted in Subparagraph (2)(a) of this Subsection.

(c) Notify all named defendants by certified mail, return receipt requested, whether or not qualified under the provisions of this Part, that a filing has been made against them and request made for the formation of a medical review panel; and forward a copy of the proposed complaint to each named defendant at his last and usual place of residence or his office.

(4) The board shall notify the claimant and all named defendants by certified mail, return receipt requested, of any of the following information:

(a) The date of receipt of the filing fee.

(b) That no filing was due because the claimant timely provided the affidavit set forth in Item (1)(d)(i) of this Subsection.

(c) That the claimant has timely complied with the provisions of Item (1)(d)(ii) of this Subsection.

(d) That the required filing fee was not timely paid pursuant to Subparagraph (1)(c) of this Subsection.

(5) In the event that any notification by certified mail, return receipt requested, provided for in Paragraphs (3) and (4) of this Subsection is not claimed or is returned undeliverable, the

board shall provide such notification by regular first class mail, which date of mailing shall have the effect of receipt of notice by certified mail.

(6) In the event the board receives a filing fee that was not timely paid pursuant to Subparagraph (1)(c) of this Subsection, then the board shall return, or refund the amount of, the filing fee to the claimant within thirty days of the date the board receives the untimely filing fee.

B.(1)(a)(i) No action against a health care provider covered by this Part, or his insurer, may be commenced in any court before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this Section.

(ii) A certificate of enrollment issued by the board shall be admitted in evidence.

(b) However, with respect to an act of malpractice which occurs after September 1, 1983, if an opinion is not rendered by the panel within twelve months after the date of notification of the selection of the attorney chairman by the executive director to the selected attorney and all other parties pursuant to Paragraph (1) of Subsection C of this Section, suit may be instituted against a health care provider covered by this Part. However, either party may petition a court of competent jurisdiction for an order extending the twelve month period provided in this Subsection for good cause shown. After the twelve month period provided for in this Subsection or any court-ordered extension thereof, the medical review panel established to review the claimant's complaint shall be dissolved without the necessity of obtaining a court order of dissolution.

(c) By agreement of all parties, the use of the medical review panel may be waived.

(d) By agreement of all parties and upon written request to the attorney chairman, an expedited medical review panel process may be selected. Unless otherwise specified in the provisions of Subsection N of this Section, the expedited process shall be governed by other provisions of this Section.

(2)(a) A health care provider, against whom a claim has been filed under the provisions of this Part, may raise peremptory exceptions of no right of action pursuant to Code of Civil Procedure Article 927(6) or any exception or defenses available pursuant to R.S. 9:5628 in a court of competent jurisdiction and proper venue at any time without need for completion of the review process by the medical review panel.

(b) If the court finds that the claim had prescribed or otherwise was perempted prior to being filed, the panel, if established, shall be dissolved upon the judgment becoming final. If the court grants the peremptory exception of no right of action as to all claimants, the panel, if established, shall be dissolved upon the judgment becoming final. If the court grants the peremptory exception of no right of action as to less than all claimants, the claimants as to whom the court granted the peremptory exception of no right of action shall be prohibited from participating in the panel process as a claimant.

(3) Ninety days after the notification to all parties by certified mail by the attorney chairman or the board of the dissolution of the medical review panel or ninety days after the expiration of any court-ordered extension as authorized by Paragraph (1) of this Subsection, the suspension of the running of prescription with respect to a qualified health care provider shall cease.

C. The medical review panel shall consist of three health care providers who hold unlimited licenses to practice their profession in Louisiana and one attorney. The parties may agree on the attorney member of the medical review panel. If no attorney for or representative of any health care provider named in the complaint has made an appearance in the proceedings or made written contact with the attorney for the plaintiff within forty-five days of the date of

receipt of the notification to the health care provider and the insurer that the required filing fee has been received by the patient's compensation board as required by R.S. 40:1299.47(A)(1)(c), the attorney for the plaintiff may appoint the attorney member of the medical review panel for the purpose of convening the panel. Such notice to the health care provider and the insurer shall be sent by registered or certified mail, return receipt requested. If no agreement can be reached, then the attorney member of the medical review panel shall be selected in the following manner:

(1)(a) The office of the clerk of the Louisiana Supreme Court, upon receipt of notification from the board, shall draw five names at random from the list of attorneys who reside or maintain an office in the parish which would be proper venue for the action in a court of law. The names of judges, magistrates, district attorneys and assistant district attorneys shall be excluded if drawn and new names drawn in their place. After selection of the attorney names, the office of the clerk of the supreme court shall notify the board of the names so selected. It shall be the duty of the board to notify the parties of the attorney names from which the parties may choose the attorney member of the panel within five days. If no agreement can be reached within five days, the parties shall immediately initiate a procedure of selecting the attorney by each striking two names alternately, with the claimant striking first and so advising the health care provider of the name of the attorney so stricken; thereafter, the health care provider and the claimant shall alternately strike until both sides have stricken two names and the remaining name shall be the attorney member of the panel. If either the plaintiff or defendant fails to strike, the clerk of the Louisiana Supreme Court shall strike for that party within five additional days.

(b) After the striking, the office of the board shall notify the attorney and all other parties of the name of the selected attorney.

(2) The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed complaint. The chairman shall establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities within ninety days following selection of the panel.

(3)(a) The plaintiff shall notify the attorney chairman and the named defendants of his choice of a health care provider member of the medical review panel within thirty days of the date of certification of his filing by the board.

(b) The named defendant shall then have fifteen days after notification by the plaintiff of the plaintiff's choice of his health care provider panelist to name the defendant's health care provider panelist.

(c) If either the plaintiff or defendant fails to make a selection of health care provider panelist within the time provided, the attorney chairman shall notify by certified mail the failing party to make such selection within five days of the receipt of the notice.

(d) If no selection is made within the five day period, then the chairman shall make the selection on behalf of the failing party. The two health care provider panel members selected by the parties or on their behalf shall be notified by the chairman to select the third health care provider panel member within fifteen days of their receipt of such notice.

(e) If the two health care provider panel members fail to make such selection within the fifteen day period allowed, the chairman shall then make the selection of the third panel member and thereby complete the panel.

(f) A physician who holds an unrestricted license to practice medicine by the Louisiana State Board of Medical Examiners and who is engaged in the active practice of medicine in this

state, whether in the teaching profession or otherwise, shall be available for selection as a member of a medical review panel.

(g) Each party to the action shall have the right to select one health care provider and upon selection the health care provider shall be required to serve.

(h) When there are multiple plaintiffs or defendants, there shall be only one health care provider selected per side. The plaintiff, whether single or multiple, shall have the right to select one health care provider, and the defendant, whether single or multiple, shall have the right to select one health care provider.

(i) A panelist so selected and the attorney member selected in accordance with this Subsection shall serve unless for good cause shown may be excused. To show good cause for relief from serving, the panelist shall present an affidavit to a judge of a court of competent jurisdiction and proper venue which shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. A health care provider panelist may also be excused from serving by the attorney chairman if during the previous twelve-month period he has been appointed to four other medical review panels. In either such event, a replacement panelist shall be selected within fifteen days in the same manner as the excused panelist.

(j) If there is only one party defendant which is not a hospital, community blood center, tissue bank, or ambulance service, all panelists except the attorney shall be from the same class and specialty of practice of health care provider as the defendant. If there is only one party defendant which is a hospital, community blood center, tissue bank, or ambulance service, all panelists except the attorney shall be physicians. If there are claims against multiple defendants, one or more of whom are health care providers other than a hospital, community blood center, tissue bank, or ambulance service, the panelists selected in accordance with this Subsection may also be selected from health care providers who are from the same class and specialty of practice of health care providers as are any of the defendants other than a hospital, community blood center, tissue bank, or ambulance service.

(4) When the medical review panel is formed, the chairman shall within five days notify the board and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

(5) Before entering upon their duties, each voting panelist shall subscribe before a notary public the following oath:

"I, (name) do solemnly swear/affirm that I will faithfully perform the duties of medical review panel member to the best of my ability and without partiality or favoritism of any kind. I acknowledge that I represent neither side and that it is my lawful duty to serve with complete impartiality and to render a decision in accordance with law and the evidence."

The attorney panel member shall subscribe to the same oath except that in lieu of the last sentence thereof the attorney's oath shall state:

"I acknowledge that I represent neither side and that it is my lawful duty to advise the panel members concerning matters of law and procedure and to serve as chairman."

The original of each oath shall be attached to the opinion rendered by the panel.

(6) The party aggrieved by the alleged failure or refusal of another to perform according to the provisions of this Section may petition any district court of proper venue over the parties for an order directing that the parties comply with the medical review panel provisions of the medical malpractice act.

(7) A panelist or a representative or attorney for any interested party shall not discuss with other members of a medical review panel on which he serves a claim which is to be

reviewed by the panel until all evidence to be considered by the panel has been submitted. A panelist or a representative or attorney for any interested party shall not discuss the pending claim with the claimant or his attorney asserting the claim or with a health care provider or his attorney against whom a claim has been asserted under this Section. A panelist or the attorney chairman shall disclose in writing to the parties prior to the hearing any employment relationship or financial relationship with the claimant, the health care provider against whom a claim is asserted, or the attorneys representing the claimant or health care provider, or any other relationship that might give rise to a conflict of interest for the panelists.

D.(1) The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only.

(2) The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, interrogatories, affidavits and reports of medical experts, and any other form of evidence allowable by the medical review panel.

(3) Depositions of the parties and witnesses may be taken prior to the convening of the panel.

(4) Upon request of any party, or upon request of any two panel members, the clerk of any district court shall issue subpoenas and subpoenas duces tecum in aid of the taking of depositions and the production of documentary evidence for inspection and/or copying.

(5) The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in Subsection G.

(6) A copy of the evidence shall be sent to each member of the panel.

E. Either party, after submission of all evidence and upon ten days notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal.

F. The panel shall have the right and duty to request and procure all necessary information. The panel may consult with medical authorities, provided the names of such authorities are submitted to the parties with a synopsis of their opinions and provided further that the parties may then obtain their testimony by deposition. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel.

G. The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty days, render one or more of the following expert opinions, which shall be in writing and signed by the panelists, together with written reasons for their conclusions:

(1) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(2) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(3) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court.

(4) When Paragraph (1) of this Subsection is answered in the affirmative, that the conduct complained of was or was not a factor of the resultant damages. If such conduct was a factor, whether the plaintiff suffered: (a) any disability and the extent and duration of the disability, and (b) any permanent impairment and the percentage of the impairment.

H. Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this Part.

I.(1)(a) Each physician member of the medical review panel shall be paid at the rate of twenty-five dollars per diem, not to exceed a total of three hundred dollars for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses.

(b) The attorney chairman of the medical review panel shall be paid at the rate of one hundred dollars per diem, not to exceed a total of two thousand dollars for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses. Additionally, the attorney chairman shall be reimbursed for all reasonable out-of-pocket expenses incurred in performing his duties for each medical review panel. The attorney chairman shall submit the amount due him for all work performed as a member of the panel by affidavit, which shall attest that he has performed in the capacity of chairman of the medical review panel and that he was personally present at all the panel's meetings or deliberations.

(2)(a) The costs of the medical review panel shall be paid by the health care provider if the opinion of the medical review panel is in favor of said defendant health care provider.

(b) The claimant shall pay the costs of the medical review panel if the opinion of the medical review panel is in favor of the claimant. However, if the claimant is unable to pay, the claimant shall submit to the attorney chairman prior to the convening of the medical review panel an in forma pauperis ruling issued in accordance with Louisiana Code of Civil Procedure Article 5181 et seq. by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process. Upon timely receipt of the in forma pauperis ruling, the costs of the medical review panel shall be paid by the health care provider, with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the medical review panel costs will be offset.

(c) In a medical malpractice suit filed by the claimant in which a unanimous opinion was rendered in favor of the defendant health care provider as provided in the expert opinion stated in Paragraph (G)(2) of this Section, the claimant who proceeds to file such a suit shall be required to post a cash or surety bond, approved by the court, in the amount of all costs of the medical review panel. Upon the conclusion of the medical malpractice suit, the court shall order that the cash or surety bond be forfeited to the defendant health care provider for reimbursement of the costs of the medical review panel, unless a final judgment is rendered finding the defendant liable to the claimant for any damages. If a final judgment is rendered finding the defendant

liable to the claimant for any damages, the court shall order that the defendant health care provider reimburse the claimant an amount equal to the cost of obtaining the cash or surety bond posted by the claimant.

(d) In the event a medical review panel renders a unanimous opinion in favor of the claimant as provided in the expert opinions stated in Paragraphs (G)(1) and (4) of this Section, and the claimant has not timely submitted an in forma pauperis ruling to the panel's attorney chairman, and thereafter the defendant health care provider failed to settle the claim with the claimant resulting in the claimant filing a malpractice suit in a court of competent jurisdiction and proper venue against the defendant health care provider based on the same claim which was the subject of the unanimously adverse medical review panel opinion against the defendant health care provider, the defendant health care provider shall be required to post a cash or surety bond, approved by the court, in the amount of all costs of the medical review panel. Upon the conclusion of the medical malpractice suit, the court shall order that the cash or surety bond be forfeited to the claimant for reimbursement of the costs of the medical review panel, unless a final judgment is rendered finding that the defendant health care provider has no liability for damages to the claimant. If a final judgment is rendered finding that the defendant health care provider has no liability for damages to the claimant, the court shall order that the claimant reimburse the defendant health care provider an amount equal to the cost of obtaining the cash or surety bond posted by the defendant health care provider.

(3) If the medical review panel decides that there is a material issue of fact bearing on liability for consideration by the court, the claimant and the health care provider shall split the costs of the medical review panel. However, in those instances in which the claimant is unable to pay his share of the costs of the medical review panel, the claimant shall submit to the attorney chairman prior to the convening of the medical review panel an in forma pauperis ruling issued in accordance with Louisiana Code of Civil Procedure Article 5181 et seq., by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process. Upon timely receipt of the in forma pauperis ruling, the costs of the medical review panel shall be paid by the defendant health care provider with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the claimant's share of the costs of the medical review panel will be offset.

(4) Upon the rendering of the written panel decision, if any one of the panelists finds that the evidence supports the conclusion that a defendant health care provider failed to comply with the appropriate standard of care as charged in the complaint, each defendant health care provider as to whom such a determination was made shall reimburse to the claimant that portion of the filing fee applicable to the claim against such defendant health care provider or if any one of the panelists finds that the evidence supports the conclusion that there is a material issue of fact, not requiring expert opinion, bearing on liability of such defendant health care provider for consideration by the court, each such defendant health care provider as to whom such a determination was made shall reimburse to the claimant fifty percent of that portion of the filing fee applicable to the claim against such defendant health care provider.

J. The chairman shall submit a copy of the panel's report to the board and all parties and attorneys by registered or certified mail within five days after the panel renders its opinion.

K. Repealed by Acts 2005, No. 127, §2.

L. Where the medical review panel issues its opinion required by this Section, the suspension of the running of prescription shall not cease until ninety days following notification

by certified mail to the claimant or his attorney of the issuance of the opinion as required by Subsection J of this Section.

M. Legal interest shall accrue from the date of filing of the complaint with the board on a judgment rendered by a court in a suit for medical malpractice brought after compliance with this Part.

N.(1)(a)(i) Parties seeking an expedited panel process pursuant to the provisions of Subparagraph (B)(1)(d) of this Section shall request such process in writing sixty days from the date of the letter of notification of the selection of the attorney chairman pursuant to Paragraph (1) of Subsection C of this Section. When a written request for an expedited medical review panel process has been made to the attorney chairman, the chairman shall establish a schedule for submission of evidence to the medical review panel within ninety days following selection of the third physician member of the panel so that a panel opinion is rendered within twelve months of the date of notification of the selection of the attorney chairman.

(ii) In accordance with Subsection J of this Section, the chairman shall submit a copy of the panel's report to the board and all parties and attorneys by registered or certified mail within five days after the panel renders its opinion. In accordance with Subsection L of this Section, where the medical review panel issues its opinion required by this Section, the suspension of the running of prescription shall not cease until ninety days following notification by certified mail to the claimant or his attorney of the issuance of the opinion as required by Subsection J of this Section.

(b)(i) No party may petition a court for an order extending the twelve month period provided in Subparagraph (B)(1)(b) of this Section. If an opinion is not rendered by the panel within the twelve month period established in this Subsection, suit may be instituted against the health care provider.

(ii) In accordance with R.S. 40:1299.47(B)(1)(b), after the twelve month period provided for in this Subsection, the medical review panel established to review the claimant's complaint shall be dissolved without the necessity of obtaining a court order of dissolution.

(iii) In accordance with R.S. 40:1299.47(B)(3), ninety days after the notification to all parties by certified mail by the attorney chairman of the board of the dissolution of the medical review panel, the suspension of the running of prescription with respect to a qualified health care provider shall cease.

(2) During selection of the physician members of the medical review panel, the plaintiff shall notify the attorney chairman and the named defendants of his choice of a health care provider member of the medical review panel within ten days of the date of written request to the chairman for an expedited panel process. The named defendant shall then have five days after notification by the plaintiff of the plaintiff's choice of his health care provider panelist to name the defendant's health care provider panelist. If no selection is made within the five and ten day respective periods, then the chairman shall make the selection on behalf of the failing party. The two health care provider panel members selected by the parties or on their behalf shall be notified by the chairman to select the third health care provider panel member within fifteen days of their receipt of such notice from the chairman to make the selection. If no selection is made within the fifteen day period, then the chairman shall make the selection on behalf of the two health care provider panel members.

(3)(a) Within thirty days of the parties' written request for an expedited medical review panel process to the attorney chairman, the claimant shall provide all defendants with a list of the names and addresses of all known health care providers, including individuals and entities, who

have treated the patient during the time period starting from three years prior to the date of the alleged malpractice up to and including the date that the list is provided. The claimant shall make a good faith effort to identify the treating health care providers.

(b) The claimant shall execute and provide all defendants with a HIPAA Compliant Authorization form to permit the defendants to obtain the medical records.

(c) An order to protect the medical records may be sought as provided in Code of Civil Procedure Article 1426 or the HIPAA regulations at 45 CFR 164.512(e) in a court of competent jurisdiction and proper venue.

(d) If an authorization is not provided or a protective order is not obtained within thirty days following the written request by the parties to the chairman for an expedited medical review panel process, the medical review panel shall lose its expedited status and no longer be governed by the provisions of this Subsection. The attorney chairman shall provide notice of this to the board and all parties by registered or certified mail.

(4)(a) The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only, according to the schedule established by the chairman.

(b) The evidence may consist only of medical charts, x-rays or other film studies, lab tests, other diagnostic or medical tests, and a position paper submitted by or on behalf of each party.

(c) Neither interrogatories to nor depositions of the parties and witnesses may be taken prior to the convening of the panel.

(d) No party or panel member shall be permitted to request the clerk of any district court to issue subpoenas and subpoenas duces tecum in aid of the taking of depositions and the production of documentary evidence. However, if a copy of the medical record is not produced by a health care provider within a reasonable period of time, not to exceed fifteen days, following a health care provider's receipt of a medical authorization executed by the claimant pursuant to Subparagraph (3)(b) of this Subsection then the party who forwarded the authorization to the health care provider may request the clerk of any district court to issue subpoenas and subpoenas duces tecum in aid of the production of the medical records.

(5) The attorney chairman, after submission of all evidence and upon ten days notice, shall convene the panel at a time and place agreeable to the members of the panel, but in no event shall the opinion be rendered later than twelve months from the date of notification of the selection of the attorney chairman by the executive director to the selected attorney and all other parties pursuant to Paragraph (1) of Subsection C of this Section. Either party may informally question the panel concerning any matters relevant to issues to be decided by the panel before and after the issuance of their report. The panel deliberation and the questioning of the panel shall not be recorded. The chairman of the panel shall preside at all meetings.

(6) The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty days, but in no event later than twelve months of the date of notification of the selection of the attorney chairman pursuant to Paragraph (1) of Subsection C of this Section, render one or more of the following expert opinions, which shall be in writing and signed by the panelists, together with written reasons for their conclusions:

(a) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court.

(7) The report of the expert opinion reached by the expedited medical review panel process pursuant to the provisions of this Subsection shall not be admissible as evidence in any action subsequently brought by the claimant in a court of law. Neither party shall have the right to call any member of the medical review panel as a witness. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this Part.

(8) The provisions of Subparagraphs (I)(2)(c) and (d) of this Section shall not apply to a medical review panel governed by the expedited medical review panel process.

Amended by Acts 1991, No. 661, §1; Acts 1991, No. 668, §1; Acts 1992, No. 347, §1, eff. June 17, 1992; Acts 1995, No. 1258, §1; Acts 1997, No. 664, §1; Acts 1997, No. 830, §1; Acts 1999, No. 610, §1; Acts 2002, 1st Ex. Sess., No. 86, §1; Acts 2003, No. 484, §1; Acts 2003, No. 644, §1; Acts 2003, No. 961, §1; Acts 2003, No. 1263, §1, eff. July 7, 2003; Acts 2004, No. 306, §1; Acts 2004, No. 309, §1; Acts 2004, No. 311, §1; Acts 2005, No. 127, §§1, 2; Acts 2006, No. 323, §1; Acts 2008, No. 558, §1; Acts 2012, No. 802, §1.

§1299.48. Reporting of claims

A. For the purpose of providing the various licensing boards of Louisiana health care providers, as defined by R.S. 40:1299.41(A), with information on malpractice claims paid by insurers or self insurers on behalf of health care providers in this state, each insurer of such health care provider, and each health care provider in Louisiana who is self insured shall, within thirty days of the date of payment, provide a written report to the licensing board of this state having licensing authority over the health care provider on whose behalf payment was made, and each such report shall contain:

(1) The name and address of the health care provider.

(2) A brief description of the acts of omission or commission which gave rise or allegedly gave rise to the claim, and the date thereof.

(3) The name of the patient and the injury which resulted or allegedly resulted therefrom.

(4) The amount paid in settlement or discharge of the claim, whether paid by compromise, by payment of judgment, by payment of arbitration award, or otherwise; and

(5) Where any judicial opinion has been rendered with regard to a claim, a copy of all such opinions shall be attached to the report.

Provided, however, no report shall be required for compromise settlements of claims where the amount paid is one thousand dollars or less, except where such payments were made in satisfaction or compromise of judgment of court or of award of arbitrators.

B. The provisions of this Section shall apply to all health care providers in Louisiana, whether or not such health care provider has qualified under the provisions of this Part.

C. There shall be no liability on the part of any insurer or person acting for said insurer, for any statements made in good faith in the reports required by this Section.

Added by Acts 1976, No. 114, §1.

§1299.49. Medical review panel; one panel for state and private claims

The following provisions shall apply when, for the same injury to or death of a patient, a malpractice claim alleges liability of both a state health care provider under the provisions of this Part and a health care provider under the provisions of Part XXI-A of this Chapter:

(1) Unless all parties have agreed otherwise, only one medical review panel shall be convened in such instance to review the claims under this Part and Part XXI-A of this Chapter.

(2) The panel shall consist of a single attorney chairperson and three health care providers who hold unlimited licenses to practice their profession in Louisiana.

(3) The panel shall be considered a joint medical review panel, and its actions shall be deemed to have the same force and effect as if a separate medical review panel had been convened under each of the respective Parts.

(4) The panel shall be governed by the law applicable under both Parts. In the event of a procedural conflict between the provisions of the Parts, the provisions of R.S. 40:1299.47 shall govern.

Acts 2004, No. 183, §1, eff. June 10, 2004.