AMENDED PLAN OF OPERATION III

including a

Dissolution Plan

LOUISIANA HEALTH PLAN

Louisiana High Risk Health Pool, Inc.
A non-profit corporation

ARTICLE I.

Name

The Plan shall be known as the Louisiana Health Plan, ("LHP" or "the Plan"), a nonprofit corporation (Louisiana High Risk Health Pool, Inc.). The Plan was created pursuant to Act 131 of the 1990 Regular Legislative Session, reenacted and amended pursuant thereto ("Act"), and may be amended from time to time thereafter. Louisiana Health Plan is incorporated as Louisiana High Risk Health Pool, Inc under the Louisiana Nonprofit Corporation laws.

With the enactment of Act 325 of the 2013 Regular Legislative Session ("Act 325"), the Plan, through its Board of Directors, ("Board"), hereby provides an orderly plan of cessation, commonly known as a Dissolution Plan ("Dissolution Plan").

This Dissolution Plan is submitted by August 30, 2013, in compliance with the requirements of Act 325.

Furthermore, this Amended Plan of Operation III includes the Dissolution Plan and shall supersede the Original Plan of Operation, Amended Plan of Operation, and Amended Plan of Operation II, as expressed herein in order to implement the requirements of the Act.

The new Plan of Operation III shall go into effect upon signature by the Commissioner.

ARTICLE II.

Membership

The Board of Directors shall be appointed and shall serve in accordance with the provisions of La. R.S. 22:1204, (as may be amended thereto) the Articles of Incorporation, and the By-Laws.

The Board shall remain in effect in accordance with provisions of R.S. 22:1205. The term of each board member shall be extended until the date the High Risk Pool concludes all business and the Commissioner of Insurance has certified the cessation of operations as defined in Article IV of this Plan of Operation III.

Any action against the Plan, the Board, the employees of the Plan, or any combination thereof shall be subject to a peremptive period ending on December 31, 2014, at which time the right to assert a cause of action shall be extinguished.

All appeals by policyholders or providers must be made within the guidelines of the policy. In no event shall any appeal by a policyholder or provider be commenced after September 30, 2014.

Nothing shall limit the immunity from liability provided by La. R.S. 22: 1203 (D).

Nothing shall prohibit the Plan from ceasing coverage or enrollment in the Plan prior to January 1, 2014, if approved by the Commissioner, in a superseding Plan of Operation as provided for in La. R.S. 22:1205 C. (7).

Since its inception in 1990, LHP has offered comprehensive health care coverage to Louisiana citizens who are not otherwise able to obtain health insurance coverage meeting prescribed criteria. The cost of such coverage is offset by the premiums paid by the enrollees, a statutory service charge on hospital and related admissions, and direct Legislative appropriations. Existing and new enrollees in the state sponsored coverage will be designated as "non-Federally defined eligible individuals" or enrollees of the "High Risk Pool" Plan.

Congress enacted the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA (Public Law 104-191). Pursuant to Act 1154 of the 1997 Louisiana Legislature, LHP was designated to provide, under federal law, guaranteed continuous access to individual comprehensive health care coverage to Louisiana citizens who lose their group health insurance coverage. The cost of such coverage will be paid by premiums from enrollees, and, to the extent necessary, by assessments of admitted health insurers, as defined. Enrollees in the federally guaranteed coverage will be designated as "Federally defined eligible individuals" or enrollees of the "HIPAA Plan".

The State of Louisiana, through the Commissioner of Insurance, has elected to implement an alternate plan to the "federal default" provisions of HIPAA. The provisions of HIPAA are implemented and enforced by the Commissioner of Insurance, as directed and authorized by Act 1138 of 1997, and particularly, but not exclusively, by the provisions of La. R.S. Statutes Title 22:250.10 (and any and all amendments thereto).

No new members shall be enrolled in the HIPAA Plan after 11:58 p.m. Central Time, December 31, 2013. No new members shall be enrolled in the High Risk Pool Plan after 11:58 p.m. Central Time, December 31, 2013.

Current enrollees in the HIPAA Plan and High Risk Pool Plan shall terminate coverage at 11:59 p.m. Central Time, December 31, 2013.

The Plan shall provide at least ninety (90) days notice to current enrollees prior to termination of coverage on December 31, 2013.

1. The means of notification shall be provided to the Commissioner and/or his appointee through the Marketing Plan and Operating Rules

2. Such notification shall be provided at least thirty (30) days prior to distribution. The exception shall be forty-eight (48) hour notification in the event of emergency notification such as:

    a. Changes in federal notification requirements
    b. Changes in federal law
    c. Unforeseen events agreed to by both the Plan and the Commissioner and/or his appointee as to require immediate notification

The Plan shall provide at least thirty (30) days notice to agents of current enrollees, prior to termination of coverage on December 31, 2013.

The Plan shall make every reasonable effort to notify providers at least thirty (30) days prior to termination of coverage on December 31, 2013.

Such notice to providers shall also contain information as to where and how to file claims, the shortened time period for claims filing, the appeals process, and the peremptive period established under Act 325.

1. The means of notification shall be provided to the Commissioner and/or his appointee through the Marketing Plan and Operating Rules

2. Such notification shall be provided at least thirty (30) days prior to distribution. The exception shall be forty-eight (48) hour notification in the event of emergency notification such as:

    a. Changes in federal notification requirements
    b. Changes in federal law
    c. Unforeseen events agreed to by both the Plan and the Commissioner and/or his appointee as to require immediate notification

Under the provisions of Act 325, the Commissioner and/or his appointee shall advise the Plan of the following:

1. That there is a minimum of one individual health insurance company authorized to provide individual health insurance coverage in the state at a rate not to exceed the usual and customary rate as of January 1, 2014.

2. If there is NO other individual health insurance company authorized to provide individual health insurance coverage in this state as of January 1, 2014.

    a. The Commissioner and/or his appointee shall notify the Plan of <u>no</u> individual company providing coverage.
    b. Under the provisions of Act 325, R.S. 1205 C. (c) (ii), the Plan shall continue to provide such coverage until there is a minimum of one (1) individual health insurance company authorized to provide individual health insurance coverage in this state on or after January 1, 2014.

After plan coverage terminates pursuant to La. R.S. 22:1205 C. (7), the Board shall take reasonable steps to dissolve all significant operations of the Plan by December 31, 2015.

ARTICLE III.

Procedures for the handling and accounting of assets and monies of the Plan

Fiscal periods, audits, banking and accounting procedures shall be as provided in the Articles of Incorporation, By-Laws, Operating Rules, and the Act.

Accounting procedures shall be established and maintained in conjunction with recommendations from the independent certified public accountant and/or actuarial consultants retained by the Board.

Record documentation and reports shall be as provided in the Articles of Incorporation, By-laws, Operating Rules, and the Act.

The Board may conduct a study of the claims loss experience of the Pool in conjunction with retained actuarial consultants and recommend adjustments to the Plan to reflect the finding of the study. The Board may also recommend amendments to the Act to the Louisiana Legislature to address the claims loss experience of the pool.

Reports shall be provided to the Board of Directors at least twice yearly providing a listing of assets and monies, as well as expenses and liabilities, of the Plan. LHP will establish and maintain two (2) separate accounts or books of business, to be denominated as follows:

1. The account for non-federally defined eligible individual, which shall include the capital and surplus of LHP ("Non-Federal or High Risk Pool Account").

2. The account for federally defined eligible individuals ("Federal Account or HIPAA Account").

The accounting systems, policies and procedures with respect to the accounts shall be subject to the review and approval of the Commissioner of Insurance.

After the Commissioner has certified the Cessation of Operations of the High Risk Pool, HIPAA Plan, and/or both, under Article XIV. of this Amended Plan of Operation III, the following shall occur:

a. Upon certification of cessation of the HIPAA Plan: if the Board has excess HIPAA funds, the excess funds shall be returned to the participating insurer on the same basis upon which each participating insurer was assessed in accordance with the provisions of La. R.S. 22:1210 during calendar years 2013 and 2014.

b. Upon certification of cessation of the High Risk Pool: if the Board has excess High Risk Pool funds, the High Risk Pool funds shall be returned to the state general fund.

ARTICLE IV.

Procedures for the payment of expenses incurred by an administering insurer in the performance of its services.

The Board shall select an administrator or administrators, which may consist of an insurer or insurers, a third-party administrator or administrators, medical, pharmaceutical providers and ancillary providers, or a combination thereof, through a competitive bidding process, to administer the benefits plan of LHP pursuant to the provisions of La. R.S. 22:1208 et seq.

The Plan may handle administration itself if it is in the best interest of the Plan to do so.

"Insurer" for purposes of this Section is defined in La. R.S. 22:1202(19).

Expenses shall be paid to the administrator, only upon receipt of written documentation of the expense and upon verification that such expense was incurred in the performance of services rendered to the Plan.

The Board shall have the power to audit such activities to verify same. The Board may, at its discretion, provide forms for expense submission.

Until the cessation of the Plan's operations, the board may continue to use existing contractors without the need to issue competitive requests for proposals.

Any action against the Plan, the Board, the employees of the Plan, or any combination thereof shall be subject to a peremptive period ending on December 31, 2014, at which time the right to assert a cause of action shall be extinguished.

All appeals by policyholders or providers must be made within the guidelines of the policy. In no event shall any appeal by a policyholder or provider be commenced after September 30, 2104.

Nothing shall limit the immunity from liability provided by La. R.S. 22: 1203 (D).

ARTICLE V.

Procedures for the reporting and remittance of charges under R.S. 22:1209, to provide for claims paid under the benefits plan, and for administrative expenses incurred for the operation of the Plan.

1. Louisiana Mandated Service Charges (Service Charges)

    a. Shall be collected, reported, and remitted per Plans A and B (Attached), as revised pursuant to statutory amendments to R.S.22:1209.

    b. Billing of Service Charges by providers pursuant to R.S. 22:1209 shall cease for claims incurred before January 1, 2014.

    c. Final service charge fees and reports shall be due and payable by Insurance Carriers or Insurance Arrangements, as defined, on January 31, 2014.

    d. Collection of all service charges legally due shall continue until cessation of operations. Nothing herein shall prohibit the auditing of any and all eligible providers, employers, insurance arrangements, or insurers carriers.

2. Assessments

    a. The following information will be provided to LHP by the Department of Insurance and will be the basis upon which LHP will calculate the assessments:

        (1) Each participating insurer's gross premiums earned on business in this State for policies or contracts covered under La R.S. 22:1210 for the most recent calendar year for which information is available.

(2) The total gross premiums earned on business in this state for policies or contracts covered under La R.S. 22:1210 for the most recent calendar year for which information is available.

b. In addition and in supplement to the provisions of La R.S. 22:1210, LHP will assess fees to participating insurers as follows:

(1) At any time the capital and surplus of LHP is used to pay any sum due under the Federal or HIPAA Account.

(2) At any time LHP determines, as certified by an independent outside actuarial firm, that there are insufficient funds to pay anticipated Federal or HIPAA Account obligations.

(3) At any time LHP prospectively determines, as certified by an independent outside actuarial firm, that there are insufficient funds to pay anticipated Federal or HIPAA Account obligations.

c. All assessments shall be subject to review and approval by the Commissioner of Insurance.

d. Calculation of assessments shall be made as follows:

i. For the purposes of this section, "participating insurer" includes all insurers providing health insurance coverage, including excess or stop loss coverage, to residents of this state.

ii. The board shall make reasonable efforts designed to ensure that an insured individual is counted only once with respect to any assessment. For that purpose, the board shall allow a participating insurer who is an excess or stop loss insurer to exclude from its number of insured individuals those who have been counted by the primary insurer for the purpose of determining its assessment under this section. The responsibility for providing determinative documentation as to payment by the primary insurer shall be provided by the stop loss or excess insurer.

iii. The board shall have the authority to assess participating insurers in accordance with the provisions of this section, and to make interim assessments as may be reasonable and necessary for the plan's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year or the projections of future losses as calculated by the independent actuarial consultants and approved by the board of directors.

iv. Following the close of each fiscal year, the plan administrator, or the independent actuarial consultants, shall determine the net premiums (premiums less reasonable administrative expense allowances), the plan expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the plan shall be recouped by assessments apportioned by the board among participating insurers.

v. Each participating insurer's assessment shall be determined by multiplying the total assessment of all participating insurers as determined in paragraph iv. by a fraction, the numerator of which equals that of participating insurer's premium and subscriber contract charges for health insurance coverage written in the state during the preceding calendar year, and the denominator of which equals the total of all health insurance premiums by all participating insurers.

vi. If assessments exceed the plan's actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments. As used in this section, "future losses" includes reserves for incurred but not reported claims or incurred but not paid claims.

*An example of the fractional representation of the assessment is provided below:

Total Assessable Premium ÷ Total Amount of Assessment = Assessment Ratio
Assessment Ratio x Assessable Premium (Specific to each Carrier) = Assessment Amount Owed by Specific Carrier

**The Specific Amount of Assessable Premium is provided by the Louisiana Department of Insurance

vii. Effective January 1, 2014, fees assessed under the HIPAA Plan to participating health insurers and insurance arrangements under R.S. 22:1210 shall cease.

viii. Billing of the assessment for 2014-2015 claims run-out, if any, shall be based on participating health insurer premiums from calendar year 2013 and shall be made no later than February 10, 2014. Payment of the assessment shall be made by the participating health insurers no later than March 31, 2014.

ix. Any participating health insurer that has not paid the assessment for calendar year 2013 by the March 31, 2014 deadline shall be reported to the Commissioner for sanctions. Sanctions for refusal to timely pay a required assessment shall include the sanctions enumerated in R.S. 22:13 or 16, at the discretion of the Commissioner.

The Board of Directors, or the Administrator, at the direction of the Board, shall establish procedures for the payment of claims under the benefits plan and for administrative expenses incurred for the operation of the Plan. Said procedures may be established at any time, whether the benefits plan has been completed or not.

The Board is not required to revise plan benefits to comply with federal law or to maintain plan coverage for any individual after December 31, 2013.

The Board shall amend plan policies and provide adequate notice to policyholders, agents of policyholders, and providers that in order for such persons to be reimbursed, a claim for plan services is required to be filed by the earlier of one hundred eighty days after the plan coverage ends on December 31, 2013, or three hundred sixty-five days after the date of service giving rise to the claim.

Any action against the Plan, the Board, the employees of the Plan, or any combination thereof shall be subject to a peremptive period ending on December 31, 2014, at which time the right to assert a cause of action shall be extinguished. .

All appeals by policyholders or providers must be made within the guidelines of the policy. In no event shall any appeal by a policyholder or provider be commenced after September 30, 2014.

Nothing shall limit the immunity from liability provided by La. R.S. 22: 1203 (D).

ARTICLE VI.

Program to publicize the existence of the benefits plan, the eligibility requirements and procedures for enrollment of members, and to maintain public awareness of the benefits plan.

1. Program to publicize the existence of the benefits plan.
   a. See Business / Marketing Plan

2. Program to publicize the eligibility requirements.
   a. See Business / Marketing Plan

3. Procedure for enrollment of members.

   LHP may utilize selected Health Insurance Managing Agents on a regional basis. LHP may conduct a comprehensive training program for the selected Managing Agents that will include the following:*

   a. Overview of HIPAA and High Risk Pool;
   b. Benefit plans offered;
   c. Eligibility requirements;
   d. Application process;
   e. Agent selection and credentialing, if applicable;
   f. Training of Agents inclusive of a.-e., above,

Agents will verify each application for completeness prior to submission to LHP.

The Board, in its discretion, may adjust Policy Fees in accordance with the provisions of La. R.S. 22: 1206 (c) and 1206 (d).

The current policy fee payment is $100 per application in both the High Risk Pool and HIPAA Plan; where the application is accepted by LHP. Any commissions authorized in the HIPAA Plan prior to the current fee implementation will be honored until termination of the policy and will be paid annually. The plan is authorized to recoup all fees and/or commissions and reasonable expenses for any fees and/or commissions paid erroneously or improperly under La. R.S. 22:1206(c) (iii) and (d).

Nothing herein shall require, or be construed to require, the Plan, Liquidator or Commissioner to pay any policy fee, agent fee, agent commission, fees, costs, percentages or other fees or costs whatsoever after December 31, 2013 in the obtainment or retention of Plan coverage.

Nothing herein shall require, or be construed to require, the Plan, Liquidator or Commissioner to pay any policy fee, agent fee, agent commission, fees, costs, percentages or other fees or costs whatsoever in the obtainment of other coverage for any applicant, enrollee, or other potential candidate for coverage that becomes effective January 1, 2014, or thereafter, in a plan other than Louisiana Health Plan. This shall apply whether coverage is obtained through the "Exchange" or outside of the "Exchange" and shall not provide any liability, real or implied, on the part of the Louisiana Health Plan, its Board, employees, third party vendors, contractors, administrators, professionals, the Liquidator or the Commissioner.

It is the responsibility of the enrollee to obtain other coverage prior to January 1, 2014.

No liability will fall on the part of the Louisiana Health Plan, the Liquidator or the Commissioner for failure of any enrollee to obtain other coverage prior to, or with an effective date of, January 1, 2014. This includes the Board, employees, third party vendors, contractors, administrators, and/or professionals retained by the Louisiana Health Plan, Liquidator, Commissioner, or any and all combinations thereof.

Program to maintain public awareness of benefits.

g. See Business / Marketing Plan.

Notwithstanding the foregoing, LHP shall have the right to receive and process any applications for coverage which are sent to it directly by prospective enrollees, and to issue the appropriate coverage, without being liable for any agent fees.

*The use of the terms "Agent" and "Managing Agent" throughout this Plan is for convenience of reference only, and is not intended to create any relationship of agent and principal or agent and broker between LHP and any of the persons or entities which are authorized to sell its policies.

ARTICLE VII.

Procedures for the operation of the Plan to effectuate the purposes of this Part as the board in its discretion deems necessary and proper.

1. The Board established the following procedures for the operation of the Plan to effectuate the purposes of the Act pursuant to the Initial Plan of Operation, which was approved by the Acting Commissioner of Insurance on July 26, 1991.

    a. Liability and indemnification of any director, officer, employee or agent shall be as provided in the Articles of Incorporation, By-laws, and La. R.S. 22:1203 D.

2. Regarding Federally defined eligible individuals (or "HIPAA eligible individuals"), the Board, at the direction of the Commissioner of Insurance, has limited certain coverage and eligibility provisions, as hereinafter set forth:

    a. Coverage

        (1) Benefits shall be as set forth on a policy form reviewed and approved by the Commissioner of Insurance

(2) The Commissioner of Insurance may from time to time direct that certain benefits be included or excluded, to the extent necessary to have the HIPAA coverage offered by LHP conform to the comprehensive coverage available in the individual market in the state of Louisiana.

(3) The Commissioner of Insurance may from time to time direct that certain benefits be included or excluded, to the extent necessary to have the HIPAA coverage offered by LHP conform to the standards or directive of the NAIC model Health Plan for Uninsurable Individuals, as modified to conform to the requirements of HIPAA.

b. Eligibility

(1) "Federally defined eligible individuals" are those persons meeting the criteria set forth in 42 U.S.C.A. Section 300gg-41 (b), and La. R.S. 22:250.12(B) as may be hereafter amended and as implemented, interpreted and enforced by the Commissioner of Insurance of the State of Louisiana.

(2) The Commissioner of Insurance has elected to provide "association coverage" under the State alternate plan, and has directed that enrollees must meet and maintain the criteria set forth in 42 U.S.C.A. Section 300 gg-41(b), and La. R.S. 22.250.12(B) to remain eligible for membership in the Plan, and, therefore, to remain eligible for HIPAA coverage offered through LHP.

3. The Commissioner of Insurance of the State of Louisiana is the governmental entity solely responsible for the implementation, interpretation and enforcement of the federal and state statutory and regulatory requirements of HIPAA. In the event that policies, procedures or practices approved by the Commissioner of Insurance are deemed noncompliant with the requirements of HIPAA, it shall be the responsibility of the Commissioner of Insurance to consult with the appropriate federal agencies, and to initiate any required corrective action. LHP shall comply with all the law directives of the Commissioner of Insurance, and shall not be liable or responsible for any civil penalties unless it shall fail to comply with such lawful directives within the delays permitted by law.

4. The HIPAA coverage offered by LHP is the implementation of a federally mandated guarantee of health care benefits, and shall be deemed the issuance of insurance. The Commissioner of Insurance has supervisory jurisdiction over the HIPAA coverage offered by LHP as the entity designated to implement the alternate plan under Act 1138 of 1997.

5. With respect to those individuals who qualify as High Risk Pool eligible and as HIPAA eligible, such individuals shall be entitled to elect which coverage to purchase. The rejection by such dual qualified individuals of HIPAA shall not disqualify such individuals who are otherwise qualified from entering the state sponsored coverage, subject to the terms and limitations (including plan closure) of that coverage. In recognition of the fact that state sponsored coverage is subsidized in part by annual appropriations from the Legislature, and in order to maximize the benefits available to the public through the state sponsored coverage, and to minimize the expense of such coverage, in the event that dual qualified individuals elect the state sponsored High Risk Pool coverage and reject the HIPAA coverage, LHP shall impose a six to twelve month pre-existing condition exclusion period on any state sponsored coverage issued to such individuals.

6. The Board shall amend plan policies and provide adequate notice to policyholders, agents of policyholders, and providers that in order for such persons to be reimbursed, a claim for plan services is required to be filed by the earlier of one hundred eighty days after the plan coverage ends on December 31, 2013, or three hundred sixty-five days after the date of service giving rise to the claim.

7. Nothing herein shall require a higher standard of care, maintenance, review, audit, or business practice, due to the dissolution of the Plan.

8. The Board may establish such other procedures for the operation of the Plan to effectuate the purposes of the Act as the Board in its discretion deems necessary and proper.

ARTICLE VIII.

Limited Maternity Portability Benefit (HIPAA Only)

1. Maternity Care will be covered, as a limited portability benefit only, and only under the following circumstances:

   a. The HIPAA eligible enrollee is an Eligible Enrollee (i.e., not a Special Enrollee); and

   b. The HIPAA eligible enrollee had maternity benefits under her last group coverage; and

   c. The HIPAA eligible enrollee was terminated involuntarily from her last group coverage; and

   d. The HIPAA eligible enrollee was neither eligible for, nor offered, any other health coverage providing maternity benefits; and

   e. The HIPAA eligible enrollee was pregnant at the time application was made for coverage under the HIPAA policy; and

   f. The HIPAA eligible enrollee requested maternity coverage at the time application was made for coverage under the HIPAA policy.

2. In the event that all of the foregoing requirements are met, the HIPAA eligible enrollee shall have coverage for Maternity Care under the HIPAA Policy, but only for the pregnancy which existed at the time application was made for coverage under the HIPAA Policy. Coverage for Maternity Care shall be subject to all other terms, conditions, and limitations of the HIPAA Policy, including all deductibles, co-insurance requirements, and policy limits.

ARTICLE IX.

Suspension of Coverage during Periods of Ineligibility (High Risk Pool)

1. Coverage under the Policy shall be suspended with respect to any covered person during any period of time in which the covered person is ineligible for coverage under the criteria set forth in La. R.S. 22:1202 (21),(22),or a combination thereof, or as set forth in the Section of the Policy entitled "ELIGIBILITY".

2. During any period of coverage suspension, benefits shall not be owed or payable to any ineligible covered person or such ineligible covered person's assignee, nor shall any premiums be owed by, or on behalf of, such ineligible covered person.

3. If LHP should determine that coverage should be, or should have been, suspended with respect to a covered person, LHP shall immediately notify the covered person of the date of the suspension of coverage under the policy, and the reason for the ineligibility. LHP shall refund to such covered person any premiums paid by, or on behalf of, the covered person during the period of ineligibility, less any claims paid to, or on behalf of, such covered person during the period of ineligibility. In the event LHP has paid more in claims than it has received in premiums during a period of ineligibility, it shall not seek to recover such sums from the covered person, unless it determines that the covered person willfully concealed the fact of his or her ineligibility from LHP. If LHP subsequently receives reimbursement from any provider for any benefits paid during any period of ineligibility, it shall refund such amounts to the covered person to the extent such reimbursement exceeds the amount of premiums paid by, or on behalf of, an ineligible covered person.

4. Unless LHP agrees to the contrary in writing, refunds shall be made in monthly installments, in amounts equal to the monthly premiums paid by, or on behalf of, the ineligible covered person.

5. Upon the termination of ineligibility, LHP shall reinstate coverage as of the date of termination of ineligibility upon written request of the covered person, provided that the covered person provides satisfactory proof of eligibility, and pays all premiums due from the date of termination of ineligibility. Upon reinstatement, the covered person shall be restored to pre-suspension status with respect to all policy provisions, including the satisfaction of pre-existing exclusion requirements and deductibles, if these were satisfied prior to the suspension of coverage.

ARTICLE X.

Annual Renewals Required (Both Pools)

1. In each Pool, all applicants shall be required to apply annually for policy renewal, on a form to be furnished by LHP.

2. Each renewal application shall require the covered person or any other person for whom coverage is sought to affirm that all persons seeking coverage continue to meet all eligibility requirements for coverage.

3. No renewal of coverage shall be required for calendar year 2014. This is due to the termination of benefits effective December 31, 2013.

ARTICLE XI.

Data Sharing (Both Pools)

1. To the extent permitted by law, LHP shall be permitted to share non-medical data with insurers, governmental agencies, or other entities necessary or appropriate to a determination of whether the Plan's policyholders continue to meet eligibility requirements in the pools operated by LHP.

2. LHP shall use this information to determine whether eligibility requirements are being met by its policyholders, but for no other purpose, except in the case of intentional or willful misrepresentation, or when required by law or applicable regulation to divulge such information.

XII.

REPORTING

a. Legislative auditor

    1. The Plan or Liquidator shall file a timely annual audit report with the Legislative Auditor in compliance with the applicable audit standards required.

b. Louisiana House and Senate Insurance Committees

    1. By March 1, 2016, the Board or Liquidator shall file a report with both the Louisiana House Committee on Insurance and the Louisiana Senate Committee on Insurance and the Commissioner. Such report shall signify completion of the requirements of La. R.S. 22:1205 C. (7) and shall include an independent auditor's report on the financial statements of the pool. Such report shall be submitted in lieu of the written report of operation of the Plan required by R.S. 22:1204 (F). The Board or Liquidator may amend such report at a later date if necessary to complete the cessation of operations of the Plan.

c. Commissioner of Insurance

    1. By March 1, 2016, the Board or Liquidator shall file a report with both the Louisiana House Committee on Insurance and the Louisiana Senate Committee on Insurance and the Commissioner. Such report shall signify completion of the requirements of La. R.S. 22:1205 C. (7) and shall include an independent auditor's report on the financial statements of the pool. Such report shall be submitted in lieu of the written report of operation of the Plan required by R.S. 22:1204 (F). The Board or Liquidator may amend such report at a later date if necessary to complete the cessation of operations of the Plan.

XIII.

DISSOLUTION AND LIQUIDATION

a. Operational Activities

i. The Plan shall begin the implementation of its Dissolution Plan upon the date of the signature of the Commissioner to the Amended Plan of Operation III

ii. The Operating Rules shall contain the details of the Operational Activities necessary to implement the Amended Plan of Operation III (including the Dissolution Plan).

iii. The Operating Rules shall be provided to the Commissioner and/or his designee on a periodic basic designated by him or her. At a minimum, the Plan shall report to the Commissioner and/or his designee every six (6) months. The initial Operating Rules under the Dissolution Plan shall be due in a period not to exceed a six (6) months from the signing of the Amended Plan of Operation III.

b. Liquidator

i. The Board shall make all necessary efforts to close all business of the Plan by December 31, 2015.

ii. The Board may hire a Liquidator to complete any or all of the tasks required under the Dissolution Plan. Payment of the Liquidator, and all contractual obligations and rights therein, shall be made, and shall remain with the Plan.

iii. The Board shall have the right to effectuate any all necessary contracts to complete the purposes of this Dissolution Plan; the Board shall also have the right to subrogate any or all of those rights to a Liquidator.

c. Transfer of Items Necessary for Efficient, Cost Effective and Reliable means of Transfer to the Liquidator and/or Commissioner

1. Data

a. Louisiana Health Plan owns all of its data, including but not limited to, policyholder information, (premiums, identifiers, etc.), claims information, financial and other records

b. Paper data will be transferred to electronic format for storage, collection and ease of retrieval

2. Assets

a. The only other "physical" assets owned by the Plan are furniture items and office equipment.

i. These will be disposed of only after completion of use; per advice of CPA

3. Cash

a. The remaining cash will have to be determined by the Certified Public Accountants at the close of business. This will be AFTER the Commissioner Certifies the Cessation of Operations of each of the pools.

b. The distribution of the cash after Cessation of Operations for each pool is stated at Article III.

4. Bonds and/or other Securities

a. Any remaining bonds and/or other securities will have to be liquidated at the close of business. This will be AFTER the Commissioner Certifies the Cessation of Operations of each of the pools.

b. The distribution of the cash after Cessation of Operations for each pool is stated at Article III.

5. Other

a. Any remaining assets will have to be liquidated at the close of business. This will be AFTER the Commissioner Certifies the Cessation of Operations of each of the pools.

b. The distribution of the cash after Cessation of Operations for each pool is stated at Article III.

d. Errors & Omissions and Directors & Officers Coverage

i. The Board may, at its discretion, purchase Errors & Omissions and Directors & Officers coverage for the Plan.

ii. The Board may, at its discretion, prepay future premiums for Errors & Omissions and Directors & Officers coverage for the Plan due to the claims run-out, dissolution and potential liquidation issues.

e. Certified Public Accountants, Actuaries, and Other Professionals

i. The Board may, at its discretion, retain Certified Public Accountants, Independent Actuaries, Legal Counsel and Other Professionals for purposes of effectuating this Dissolution Plan

f. Claim Audits

i. The Board may, at its discretion, retain an independent professional or group of professionals to conduct claim audits that

1. includes, but is not limited to, the following:

    - Administrator and any subcontractors of the Administrator
    - Utilization Management Company
    - MNRO Company
    - Disease Management Company
    - Case Management Company
    - Pharmacy Benefits Management Company
    - Preferred Provider Organization
    - Providers
    - Insurance Agents
    - Subrogation parties
    - Any and contractors or subcontractors of the above named parties, including, but not limited to, providers of said companies
    - Intermediary data exchange parties holding information regarding any, all, or a combination of the parties
    - Banks and other banking institutions involved in premium or claims payment, or operational activities of the Plan
    - Other
        - Any and all other parties involved in any operational element of the Plan, including, but not limited to, premium, claims, disease and case management, pharmacy, ancillary, and other benefits, and any all operational activities of the Plan

Nothing herein shall require a higher standard of care, maintenance, review, audit, or business practice, due to the dissolution of the Plan.

ARTICLE XIV.

Certification of Cessation of Operations of the Louisiana Health Plan by the Commissioner of Insurance under La. R.S. 22: 1205 C. (7) (j)

b. The Commissioner shall certify the Cessation of Operations of each pool under the Louisiana Health Plan.

    i. The High Risk Pool and the HIPAA Plan may be certified as having completed the cessation of operations separately or together, at the Commissioner's discretion.

    ii. The Board may also submit the completed Dissolution Plan for the High Risk Pool and the Dissolution Plan for the HIPAA Plan at different times based upon the finality of claim submissions or other factors.

    iii. Upon a satisfactory review of the Board's compliance with the Cessation of Operations provisions of La. R.S. 22:1205 C. (7) (j), the Commissioner shall certify that the business of the Louisiana Health Plan (commonly known as the High Risk Pool) has concluded in accordance with state law. The Commissioner shall publish the certification on the Department of Insurance website.

iv. Upon completion of the Certification of Cessation by the Commissioner under the provisions in Article XIV., the operations of the Louisiana Health Plan are terminated.

v. The state attorney general shall defend any legal action that may arise against the Plan, the Board, or the employees of the Plan that is filed after the Commissioner's Certification of Cessation of Operations. This defense shall include, when appropriate, a request for dismissal of any such action.

c. After paying health insurance claims for plan coverage, meeting all other obligations of the Board set forth under La. R.S. 22:1205 C. (7), and taking all reasonable steps, including those set forth under La. R.S. 22:1205 C. (7), to timely and efficiently assist in the transition of individuals receiving plan coverage to the individual health insurance market, the board shall cease operating the Louisiana Health Plan.

ARTICLE XV.

EFFECTIVE DATE

This Amended Plan of Operation III, including the Dissolution Plan, shall become effective upon signature of the Commissioner of Insurance and shall supersede any and all previous Plans of Operation.

Approved by:

_____

James J. Donelon
Commissioner of Insurance

Date: _____

DISSOLUTION MARKETING PLAN

LOUISIANA HEALTH PLAN

1. Provide Notice to Providers of claims filing deadlines, appeal deadline and deadline for filing causes of action.

2. Provide Notice to Health Insurance Carriers and HMOs regarding assessments and Louisiana Mandated Service Charge.

3. Provide Notice to Hospitals and Outpatient Surgery Centers regarding Louisiana Mandated Service Charge.