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Department of Insurance
State of Idaho

BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE

STATE OF IDAHO

In the Matter of:	Docket No. 18-3733-19
IDAHO INDIVIDUAL HIGH RISK REINSURANCE POOL	**ORDER APPROVING PLAN OF OPERATION**

WHEREAS, Idaho Code § 41-5503 provides that the Idaho Individual High Risk Reinsurance Pool Board (the "Board"), created pursuant to Idaho Code § 41-5502, shall submit to the Director of the Idaho Department of Insurance ("Director") its plan of operation and amendments thereto, which shall become effective upon written approval of the Director; and

WHEREAS, the Board, at its meeting of August 29, 2019, voted to approve amendments to its existing plan of operation to increase the coinsurance percentage from fifty percent (50%) to sixty percent (60%) effective January 1, 2020, as reflected on Schedule B of the plan of operation; and

WHEREAS, a public hearing was noticed and held at the offices of the Idaho Department of Insurance in Boise, Idaho, on November 6, 2019, from 2:00 p.m. to 2:30 p.m., to allow interested

parties the opportunity to provide oral or written comments regarding the proposed amendments to the Board's plan of operation; and

WHEREAS, no individuals attended the public hearing, and no written comments were received; and

WHEREAS, the Board has submitted for the Director's approval its "Idaho Individual High Risk Reinsurance Pool Plan of Operation, Amended and Restated Effective January 1, 2020," which document is attached hereto as Exhibit 1; and

WHEREAS, Idaho Department of Insurance staff and its counsel have reviewed Exhibit 1 and found it to be consistent with chapter 55, title 41, Idaho Code, and by presentation of this order to the Director recommend approval of it;

NOW THEREFORE, the Director having reviewed Exhibit 1 and finding it to be consistent with the provisions of chapter 55, title 41, Idaho Code; suitable to assure the fair, reasonable, and equitable administration of the Idaho Individual High Risk Reinsurance Pool; and to provide for the sharing of pool gains or losses on an equitable and proportionate basis in accordance with the provisions of chapter 55, title 41, Idaho Code;

IT IS HEREBY ORDERED that the "Idaho Individual High Risk Reinsurance Pool Plan of Operation, Amended and Restated Effective January 1, 2020," attached hereto and incorporated herein as Exhibit 1, is hereby approved pursuant to Idaho Code § 41-5503(1).

DATED and EFFECTIVE this 18th day of November, 2019.

STATE OF IDAHO
DEPARTMENT OF INSURANCE

DEAN L. CAMERON
Director

NOTIFICATION OF RIGHTS

This is a final order of the agency. Any party may file a motion for reconsideration of this final order within fourteen (14) days of the service date of this order. The agency will dispose of the motion for reconsideration within twenty-one (21) days of its receipt, or the motion will be considered denied by operation of law. See Idaho Code § 67-5246(4).

Any such motion for reconsideration shall be served on the Director of the Idaho Department of Insurance, addressed as follows:

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043

Pursuant to Idaho Code §§ 67-5270 and 67-5272, any party aggrieved by this final order or orders previously issued in this case may file a petition for judicial review in the district court of the county in which:

i. A hearing was held;

ii. The final agency action was taken;

iii. The party seeking review of the order resides, or operates its principal place of business in Idaho; or

iv. The real property or personal property that was the subject of the agency action is located.

A petition for judicial review must be filed within twenty-eight (28) days of: (a) the service date of this final order, (b) the service of an order denying motion for reconsideration, or (c) the failure within twenty-one (21) days to grant or deny a motion for reconsideration, whichever is later. See Idaho Code § 67-5273. The filing of a petition for judicial review does not itself stay the effectiveness or enforcement of the order under appeal. Idaho Code § 67-5274.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have, on this 19th day of November, 2019, caused a true and correct copy of the foregoing ORDER APPROVING PLAN OF OPERATION to be served upon the following by the designated means:

Hyatt Erstad Chairman Idaho Individual High Risk Reinsurance Pool Board P.O. Box 2354 Boise, ID 83701	☒ first class mail ☐ certified mail ☐ hand delivery ☐ via facsimile ☐ via email
Weston Trexler Deputy Director Idaho Department of Insurance 700 W. State Street, 3rd Floor P.O. Box 83720 Boise, ID 83720-0043	☐ first class mail ☐ certified mail ☒ hand delivery ☐ via facsimile ☐ via email
Edith L. Pacillo Lead Deputy Attorney General Idaho Department of Insurance 700 W. State Street, 3rd Floor P.O. Box 83720 Boise, ID 83720-0043	☐ first class mail ☐ certified mail ☒ hand delivery ☐ via facsimile ☐ via email

Pamela Murray

Pamela Murray,
Assistant to the Director

IDAHO
INDIVIDUAL HIGH RISK
REINSURANCE POOL
PLAN OF OPERATION

AMENDED AND RESTATED

EFFECTIVE January 1, 2020

FILED January 1, 2020

EXHIBIT
1
exhibitsticker.com

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PLAN OF OPERATION

ARTICLE 1 – NAME

1.1 The Idaho Individual High Risk Reinsurance Pool (hereinafter referred to as the "pool" or IIHRRP) is an independent public body, corporate and politic. The pool performs an essential governmental function in the exercise of powers conferred upon it in Section 41-5502, Idaho Code. Any assessments imposed or collected pursuant to the operation of the pool shall at all times be free from taxation of every kind.

ARTICLE 2 – PURPOSE

2.1 The purpose of the pool is to promote the availability and affordability of individual insurance coverage in Idaho, regardless of health or claims experience, by providing a safety net to carriers in the form of a risk pool and reinsurance mechanism to facilitate the guarantee issue of state approved health benefit plans.

ARTICLE 3 – DEFINITIONS

The terms used in the Plan of Operations have the same meanings as they are given in Chapter 55, Title 41, Idaho Code ("the Act"), and are hereby adopted by reference except as specifically provided below.

3.1. "Hierarchical condition category" or "HCC" means the system of disease groupings developed by the U.S. Department of Health and Human Services (HHS), consisting of disease codes that predict average healthcare spending.

3.2. "High risk medical condition" means a medical condition or diagnosis identified in Schedule A.

ARTICLE 4 – POWERS OF THE POOL

4.1. The pool shall have the powers and authority granted by the Act.

ARTICLE 5 – PLAN OF OPERATION

5.1. The Individual High Risk Reinsurance Pool will perform its functions under this Plan of Operation, and in accordance with the Idaho Insurance Code. The Plan of Operation and any amendments necessary or suitable hereto will assure the fair, reasonable, and equitable administration of the pool and provide for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of Section 41-5503, Idaho Code. The Plan of Operation, or any amendments to the Plan of Operation, shall become effective upon the written approval by the Director.

ARTICLE 6 – BOARD OF DIRECTORS

6.1. The pool will exercise its powers through a Board of Directors. The board shall consist of ten (10) members. Eight (8) members shall be appointed by the Director and serve at the pleasure of the Director. The Director, or the Director's designated representative, shall serve as an ex-officio voting member of the board.

6.2. In selecting the members of the board, the Director shall appoint four (4) members representing carriers, two (2) disability agents and two (2) members representing consumer interest. Additionally, one (1) member shall be a member of the Senate appointed by the President Pro

Tempore of the Senate and one (1) member shall be a member of the House of Representatives appointed by the Speaker of the House. The initial non-legislative board members shall be appointed as follows; two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent non-legislative board members shall serve for a term of three (3) years. Legislative members of the board shall serve for a term of two (2) years. A vacancy in the legislative member's position on the board shall be filled in the same manner as the original appointment. All other vacancies on the board shall be filled by the Director. A non-legislative board member may be removed by the Director for cause.

6.3. There shall be no more than one (1) board member representing any one carrier.

6.4. A board member term will start upon appointment and expire upon the board member's death, resignation, or the appointment of the board member's successor.

6.5. Board members shall be eligible for reappointment. A non-legislative vacancy in the board shall be filled by the Director.

6.6. Members selected for the board shall elect a chairperson, vice chairperson and a secretary from among its members and such other officers as it deems appropriate. The terms for these offices will be for one year. Upon election, the chairperson shall notify the Director of the board's officers within thirty (30) days of said elections.

6.7. The votes of the board will be on a one-person, one-vote basis. Proxy voting is not allowed.

6.8. The majority of the board shall constitute a quorum for the transaction of business. The acts of the majority of the board present at a meeting at which a quorum is present shall be the acts of the board. Members of the board are required to disclose any potential conflict of interest prior to voting on a particular issue. The chairperson will decide whether the member with the potential conflict may vote.

6.9. An annual meeting of the board shall be held at the offices of the Department of Insurance on the second Tuesday in August of each year, unless the board designates some other date or place.

6.10. At least annually, the board shall:

6.10.1. Review this Plan of Operation and submit proposed amendments, if any, to the Director for approval;

6.10.2. Review reports of the administrator, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters;

6.10.3. Review reports of the committees established by the board;

6.10.4. Determine whether any technical corrections or amendments to the Act shall be recommended to the Director;

6.10.5. Review and give consideration to the performance of the pool in support of the goals of the Act;

6.10.6. Review the reinsurance rates and communication programs based on the provisions of the Act;

6.10.7. Review the rates, benefit design, reinsurance rates and communications programs for any high risk pool plans issued prior to April 1, 2017 and still in effect;

6.10.8. Review the net premiums, the pool administration expenses and the incurred losses for the year, taking into account investment income and other appropriate gains and losses;

6.10.9. Determine if an assessment is necessary for the proper administration of the pool; and

6.10.10. Review, consider and act on any matters deemed by the board to be necessary and proper for the administration of the pool.

6.11. The board may appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the plan, policy and contract design, and any other functions within the authority of the pool.

6.12. The board shall hold other meetings upon the request of the chairperson, or two or more members of the board, at such times and with such frequency as it deems appropriate. These meetings may be held either in person, by telephone, or by a written ballot circulated to the board members by mail, facsimile or internet e-mail, upon which each will indicate in writing his/her rejection or approval of the measure at issue. Notice of such a meeting and its purpose shall be provided to the Board of Directors at least seven (7) working days prior to the meeting, unless such notice shall be waived by unanimous consent of members of the board. At meetings other than the annual meeting, the board may perform any of the functions listed above.

6.13. The board may establish operation procedures for the pool consistent with the Act and this Plan of Operation.

6.14. A written record of the proceedings of each board meeting shall be made and submitted to the Director within thirty (30) days of said meeting by the administrator. The original of the record shall be retained by the administrator.

6.15. Board members may be reimbursed from the moneys of the pool for reasonable expenses incurred by them as members for traveling, lodging and meals upon approval of such expenses by the board, but shall not otherwise be compensated by the pool for their services.

6.16. Board members will review and act upon any other matters deemed necessary.

ARTICLE 7 – COMMITTEES

The board may appoint its members and others to the committees set forth in the Plan of Operation or otherwise established by the board. A written record of the proceedings of each committee shall be maintained by a secretary appointed from the membership of the committee.

7.1. Actuarial Committee. The mission of the Actuarial Committee is to:

7.1.1. Assist the board in the establishment or revision of reinsurance parameters, including but not limited to premium rates, the initial level of claims for which the reinsuring carrier is responsible, the coinsurance percentage at which claims above the initial level are reinsured by the pool, and the maximum claims limit above which the pool no longer reinsures.

7.1.2. Assist the board in establishing or revising the high risk medical conditions for which carriers are allowed to cede for reinsurance.

7.1.3. Assist the board in establishing or revising procedures for ceding individuals with high risk medical conditions.

7.1.4. Make recommendations to the board concerning the high risk pool plan premium rates, reinsurance premium rates, benefit design and communications programs for any high risk pool plans issued prior to April 1, 2017 ("Pool Benefit Plan") and still in effect.

7.1.5. Recommend to the board reports to be made by carriers and the administrator.

7.1.6. Provide reports and other recommendations as directed by the board.

7.1.7. Determine the incurred claim losses of the pool, including amounts for incurred but not reported claims.

7.1.8. Recommend assessment methodology and assessments.

7.1.9. Assist the board in any other actuarial-related matters deemed necessary.

7.2. Operations Committee. The mission of the Operations Committee is to:

7.2.1. Periodically review the Plan of Operation and make recommendations to the board.

7.2.3. Identify items for which operating rules are needed and to propose them for adoption by the board.

7.2.4. Assist the board in any other matters deemed necessary.

7.3. Legal Committee. The mission of the Legal Committee is to handle the following legal matters at the request of the board:

7.3.1. Interpret the provisions of the Act.

7.3.2. Review the Plan of Operation and amendments to the Plan of Operation.

7.3.3. Prepare proposed amendments to the Act.

7.3.4. Coordinate with legal counsel, as needed, on routine legal matters relating to the pool operations, including proposed contracts and operational practices.

7.3.5. Prepare contracts and legal documents for the pool as requested by the board.

7.3.6. Be familiar with, and provide assistance to, the board concerning all litigation and other disputes involving the pool and its operations.

7.3.7. Maintain a written record of all questions received and responses provided, and shall provide copies of all such responses to the board.

7.3.8. Assist the board in other legal-related matters deemed necessary.

7.4. Audit Committee. The mission of the Audit Committee shall include the following items, as well as any other appropriate tasks assigned to it by the board:

7.4.1. Develop a uniform audit program to be utilized by independent auditors in their review of pool operations related to reinsurance and assessments.

7.4.2. Establish standards of acceptability and assist the board in the selection of an independent auditor for the annual audit of the pool operations.

7.4.3. Assist the board in the review of the reports prepared by the independent auditors.

7.4.4. Assist the board on any other audit-related matters deemed necessary.

ARTICLE 8 – ADMINISTRATOR

8.1. The administrator performs the administrative functions required under this Plan of Operation. The administrator is responsible, along with the board and the carriers, for the fair, equitable and reasonable administration of the pool.

8.2. The board shall select the administrator in accordance with the procedures established and administered by the State of Idaho Division of Purchasing, if required.

8.3. The administrator shall perform the following functions as directed by the board:

8.3.1. Prepare and submit monthly reports, meeting minutes and an annual report to the Board of Directors.

8.3.2. Establish procedures and install the systems needed to properly administer the operations of the pool in accordance with the Idaho Insurance Code and this Plan of Operation.

8.3.3. Establish on behalf of the pool, one or more bank accounts for the transaction of business. These bank accounts will be approved by the board.

8.3.4. Collect reinsurance premium and collect all other amounts due to the pool on a timely basis.

8.3.5. Deposit all cash collected on behalf of the pool in the established bank account(s) on a timely basis.

8.3.6. Perform reinsurance reimbursement for claims paid.

8.3.7. Issue checks or drafts on or approve charges against bank accounts of the pool.

8.3.8. Keep all accounting, administrative and financial records of the pool in accordance with this Plan of Operation.

8.3.9. Serve as a communications resource for carriers in reviewing their operations under the Act and the Plan of Operation.

8.3.10. Calculate the assessment, in accordance with the methodology specified in the Act and this Plan of Operation, notify carriers of amounts due and collect appropriate amounts due.

8.3.11. Invest available cash in marketable securities as approved by the board.

8.3.12. Prepare an annual estimate of operating costs for the administration of pool operations.

8.3.13. Perform other functions as agreed to by the board and the administrator.

8.4. The administrator shall maintain all records as to premium, reimbursement, and administrative expense as to each calendar year for a period of seven (7) years following the end of such calendar year.

8.5. The administrator shall be reimbursed for its reasonable costs of administration in accordance with a written agreement approved by the board.

8.6. The administrator will subcontract for services which cost in excess of $10,000 only with the prior approval of the board.

8.7. The administrator shall retain the confidentiality of all information pertaining to persons insured and the carriers in accordance with all applicable statutes, regulations and principles of common law pertaining to confidentiality and trade secrets. Such information shall be used only for the purposes necessary for the operation of the pool and shall be strictly segregated from other records, data or operations of the administrator. Unless specifically required, hereunder or by the Act, no information shall be retained or used by the administrator or disclosed to any third party which information identifies a specific insured or carrier.

ARTICLE 9 – CEDING AND REINSURANCE

9.1. General Rules – Ceding Individuals with High Risk Medical Conditions for Reinsurance

9.1.1. Mandatory Ceding. Carriers shall give notice to the administrator of every individual diagnosed with a high risk medical condition within ninety (90) days of the adjudication of a claim identifying a high risk medical condition.

9.1.2. Ceding on Individual Basis. Carriers shall cede coverage on an individual rather than on a policy basis. Only the individual diagnosed with a high risk medical condition shall be reinsured; dependents or other family members of the individual shall not be reinsured, unless also diagnosed with a high risk medical condition.

9.1.3. Retroactive Coverage. Reinsurance coverage shall be retroactive to the first coverage effective day of the calendar year of the diagnosis triggering the individual's eligibility for reinsurance.

9.1.4. Late Notification. In the event that the carrier fails to notify the administrator of an individual's eligibility for reinsurance within ninety (90) days of the adjudication of a claim indicating a diagnosis of a high risk medical condition, the carrier shall be liable for reinsurance premiums retroactive to the beginning of the first coverage effective day of the calendar year of the diagnosis. Such failure to properly notify will result in denial of all of that individual's reinsurance claims incurred during the applicable calendar year.

9.1.5. Information Indicating Diagnosis of High Risk Medical Condition. Carriers shall identify individuals with a high risk medical condition based on an adjudicated claim.

9.1.6. Ceding on Calendar Year Basis. Eligible individuals will be ceded until the end of the calendar year in which the adjudicated claim was incurred. Reinsurance shall cease mid-year only for reasons identified at Section 41-5509(3), Idaho Code.

9.1.7. Claims Incurred Previous Calendar Year. If a carrier receives, on or before the last day of March of the current year, a claim which was incurred during the previous calendar year indicating an eligible individual was diagnosed with a high risk medical condition, the carrier shall give notice to the administrator within ninety (90) days of adjudication of the claim. Claims adjudicated after the last day of March of the current year but incurred during the previous year shall not be used as a basis for ceding during the current year.

9.1.8 Mid-Year Changes to Medical Conditions Eligible for Ceding. In the event Schedule A is amended during the year in accordance with Section 41-5503(1), Idaho Code to add a new high risk medical condition eligible for ceding, the date the administrator notifies the

Carrier of the change to the Schedule A shall constitute the adjudication date for purposes of this Plan of Operation with respect to any individual whose claims became newly eligible for ceding as a result of the change to Schedule A. Carriers shall provide the notice required in Section 9.1.1 by the later of the date set forth in Section 9.1.1. or within (90) days of being notified of the modification to the Schedule A with respect to any such individual newly eligible for ceding.

9.2. General Rules – High Risk Pool Plans Issued Prior to April 1, 2017

9.2.1. Notification. For each insured, including dependents, the carrier must give notice to the administrator of the inception of coverage under a basic, standard, catastrophic A or catastrophic B health insurance benefit plan within sixty (60) days from the later of (a) the date coverage became effective or (b) the date coverage was accepted by or on behalf of the insured. Notice must include all information required by the form(s) adopted by the pool and provided by the administrator.

9.2.2. Late Notification Charge. If notification is not sent within fifteen (15) days following the due date, a late notification charge equal to 100% of the monthly premium for each covered life, including dependents ("insured"), shall be imposed for each full month and each partial month that notice is delayed beyond the due date. The late notification charge is in addition to the premium earned on the covered lives. Late payment charges are addressed in Section 9.5. For purposes of this Subsection, "month" shall mean thirty (30) consecutive days.

Example 1: If coverage became effective and was accepted for an individual on Sunday, June 1, the notice must be sent within 60 days following June 1, i.e. by Thursday, July 31. If the carrier sends the pool administrator notice on Friday, August 15, such notice is within the 15 day grace period and there is no late notification charge. If, however, the notice is sent Saturday, August 16, or Monday August 18, the late charge will be equal to 1 full month's premium for the partial month the notice was delinquent.

Example 2: If coverage became effective and was accepted for a family of 2 adults and 3 children on Tuesday, July 1, the notice must be sent within 60 days, i.e. not later than August 30, except such day is a Saturday and the following days are a Sunday and a holiday -Labor Day - so the due date will be Tuesday, September 2. If the carrier does not send notice until October 3, the late notification charge will be equal to 2 months' combined premium for all 5 insureds, i.e. 1 full month's premium for the month (30 consecutive days) which elapsed from September 2 through October 2 plus an additional month's premium for the partial month (1 day) in October.

Example 3: Same facts as Example 2, except the coverage is not accepted by the insureds until July 8 (although effective July 1) and the carrier sends notice to the pool administrator on September 22. In this case, the last day for timely notification, i.e. "within 60 days", is the Monday following Saturday, September 6; and there is no late notification charge because the notice is sent within 15 days after Monday, September 8.

9.2.3. The carrier must pay all reinsurance premiums due in accordance with Section 9.5, Billing and Payment.

9.2.4. Reinsurance shall be effective on the same date as the Pool Benefit Plan coverage.

9.2.5. Any carrier issuing a Pool Benefit Plan shall receive reinsurance to the level of coverage provided in the plan, subject to retention and coinsurance requirements and subject to rescission of coverage under the general laws of insurance.

9.2.6. Each carrier reinsuring an individual or eligible dependent is responsible for ascertaining and certifying:

9.2.6.1. that the individual or dependent, is eligible; and

9.2.6.2. that the reinsurance premium rate level payable to the pool has been correctly determined.

Each carrier must also document these determinations in its reporting of reinsurance census data and reinsurance premiums to the administrator.

9.2.7. Reinsurance of an individual's coverage under the Pool Benefit Plan ceases at the termination of the individual's status as a reinsured individual or dependent except to the extent that coverage continues as required by law. If the carrier provides coverage for such persons beyond any of the dates indicated above, for contractual or other reasons, reinsurance will be available for a maximum of thirty (30) days beyond said date.

9.3. Determination of Individual High Risk Reinsurance Pool Premium. Reinsurance premium rates shall be set as determined by the board and approved by the Department.

9.4. Pool Benefit Plan Premium Rates. Premium rates for coverage under the Pool Benefit Plans (basic, standard, catastrophic A and catastrophic B health benefit plans), shall be established according to Section 41-5507, Idaho Code.

9.5. Billing and Payment

9.5.1. The payment of reinsurance premiums will be handled on a "self-billed" basis. Monthly, the carrier will provide the administrator with a listing of all reinsured individuals, the reinsurance premium for each individual and such other information as may be required by the pool. The administrator will make any necessary corrections and send the corrected statement to the carrier.

9.5.2. The reinsurance premiums charged by the pool for each individual will be determined by the board, pursuant to Section 9.3. Changes in rates will take effect not less than sixty (60) days after the board gives notice of a change in the tables of rates.

9.5.3. The reinsurance premium rates for coverage under the high risk pool plans issued prior to April 1, 2017 will be determined by the table of rates in effect on the effective date of the Pool Benefit Plan covering that individual. Changes in rates will take effect not less than sixty (60) days after the board gives notice of a change in the tables of rates. However, no such changes will apply to an in-force reinsured Pool Benefit Plan until such plan's anniversary date, unless specified in writing by the board as part of its notice. Any change in the reinsurance rates applicable to any one reinsured individual, occasioned by a change in that person's age, shall take effect on the anniversary of the Pool Benefit Plan which falls on or follows the effective date of the change.

9.5.4. Premiums are determined as of the first (1st) day of each month and are due and payable by the twentieth (20th) day of the month. A late payment charge of $100.00 for each insured individual and each insured dependent shall be imposed for failure to pay

premium by the fifth (5th) day of the following month. In addition, premium not received by the fifth (5th) day of the following month shall accrue interest at the rate of 1.5% per month from the first (1st) day of the same month until paid.

9.5.5. Reinsurance premium amounts are to be paid based on whole month increments only. If a carrier's reinsured coverage is effective between the first (1st) and the fifteenth (15th) of the month, the entire month is paid in full. When coverage becomes effective between the sixteenth (16th) and the last day of the month, no premiums will be payable until the first month following the effective date.

9.5.6. Conversely, terminations effective between the first (1st) and the fifteenth (15th) of the month will be allowed refunds for the entire month, and terminations effective between the sixteenth (16th) and the last day of the month will not be allowed a premium refund.

9.5.7. Reinsurance premium is due monthly to the pool regardless of the carrier's ability to charge back or collect the premiums. The pool has no responsibility for the collection of premiums from insured individuals.

9.6. Reinsurance Claims

9.6.1. The pool shall indemnify carriers for covered claims subject to the following:

9.6.1.1. Claims incurred by individuals ceded for reinsurance in accordance with Section 9.1 shall be reimbursed in accordance with the parameters determined by the board and described at Schedule B.

9.6.1.2. With the Director's approval, the deductible amount, threshold amount, or retention percentage may be changed by the board.

9.6.1.3. For the purposes of this Section, "covered claims" shall mean only such amounts as are actually paid by the carrier for benefits provided for individuals reinsured by the pool. Covered claims shall not include:

(a) Claim expenses or salaries paid to employees of the carrier, who are not providers of healthcare services;

(b) Court costs, attorney's fees or other legal expenses;

(c) Any amount paid by the carrier for:

(i) Punitive or exemplary damages; or

(ii) Compensatory or other damages awarded to any insured, arising out of the conduct of the carrier in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or the operation of any managed care, cost containment, or related programs;

(d) Any statutory penalty imposed upon a carrier on account of any unfair trade practice or any unfair insurance practice.

9.7. General Claims Requirements

9.7.1. Claims Reporting. Within thirty (30) days after the close of each month, the carrier shall furnish to the pool, in a form approved by the board, the following information with respect to reinsured losses submitted to the pool by the carrier during said month:

9.7.1.1. the reinsured individual's identification number;

9.7.1.2. the individual's name and social security number;

9.7.1.3. the claimant's name and date of birth;

9.7.1.4 the claim incurred date and paid date;

9.7.1.5. the reinsurance claim amount;

9.7.1.6. the claim coding (e.g., CPT and ICD9) as required by the board or;

9.7.1.7. such other information as required by the board and provided for on the administrator's reinsuring claims documentation forms.

9.7.2. Carriers shall promptly investigate, settle or defend all claims arising under the risks reinsured in a manner consistent with the carrier's non-reinsured business. Carriers shall forward promptly to the pool copies of such reports of investigation as may be requested by the pool.

9.7.3. Carriers shall adjudicate all claims on reinsured risks in a manner consistent with the carrier's non-reinsured business.

9.7.4. Each carrier shall use its cost containment programs to control costs on reinsured business to the same extent it would use such programs on its non-reinsured business, including but not limited to utilization review, individual case management, and preferred provider provisions. The failure to follow such procedures may result in the denial or reduction of reinsurance claim payments, as determined by the board.

9.7.5. The pool shall have the right, at its own expense, to participate jointly with a carrier in the investigation, adjustment or defense of any claim. Carriers will be required to assure that their claim management practices are consistent for reinsured and non-reinsured risks. The failure to follow such procedures may result in the denial or reduction of reinsurance claim payments as determined by the board.

9.7.6. The pool shall have the right to inspect the records of the carrier in connection with the risks reinsured with the pool and the carrier shall submit to the pool any additional information it may require in connection with claims submitted to the pool for reimbursement. Carriers shall secure necessary authorization from an insured for this purpose.

9.7.7. All information disclosed to the pool by the carrier or to the carrier by the pool, in connection with this plan, shall be considered by both the carrier and the pool to be privileged information.

9.7.8. If any payment is made by the pool and the carrier is reimbursed by another insurance policy for the same expenses, the pool shall be reimbursed to the extent that the carrier is reimbursed. The carrier shall execute and deliver instruments and do whatever is necessary to preserve and secure such reimbursement rights.

9.7.9. MCO's and other carriers which pay for certain provider services on a basis other than fee for service will be allowed reimbursement for those costs on reinsured persons from the pool based on the negotiated reimbursement amount.

9.7.10. Except as approved by the board, reinsurance will be provided only for covered claims submitted within ninety (90) days from the date the expenses on which the claim is based were paid, and no more than twelve (12) months from the date the expenses were incurred, unless the carrier demonstrates that the claimant was not legally capable of submitting the claims. Notwithstanding the foregoing, reinsurance will be provided for covered claims paid during the retroactive coverage period prior to the date of the adjudication of the claim first identifying the high risk medical condition, provided the carrier submits all such covered claims to the plan administrator within (90) days of the date the carrier timely provides notice of ceding in accordance with Section 9.1.1. or 9.1.8..

9.7.11. Carriers shall not delay payment of otherwise valid claims due to the transfer of risk to the pool.

9.8. Computation of Time Period. In computing a period of time allowed by this Article, the date of the event after which the period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, a Sunday or a legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, a Sunday nor a holiday. A half-holiday shall be considered as other days and not as a holiday.

9.9. Notices. All notices and other communications required or permitted by this Article shall be deemed given when (a) delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid); (b) sent by facsimile or internet e-mail with confirmation of transmission by the transmitting equipment; or (c) deposited in the U.S. mail properly addressed and with sufficient postage.

9.10. Appeals. Carriers shall have the right to appeal an action taken by the Administrator in regard to ceding and reinsurance. Carrier appeals shall adhere to the following process:

9.10.1. The carrier notifies the Administrator of the action which the carrier desires to appeal;

9.10.2. The Administrator schedules discussion and resolution of the carrier appeal for the next meeting of the board;

9.10.1. The board votes on whether to grant or to deny the appeal.

ARTICLE 10 – AUDITING FUNCTIONS

10.1. Annual Audit. Annually, the program will cause an audit to be conducted of the pool financial statements. The certified audit report shall be included in the annual fiscal report to the Director.

10.2. Audit Scope. The audit shall include the relevant operations of (i) the administrator and (ii) participating carriers. The audit report shall include the auditor's opinion as to whether the financial statements of the pool fairly present in all material respects, the financial position of the pool. Auditors of the pool shall also provide the Audit Committee and the board a report of any reportable conditions or material weaknesses in the internal controls and processes of the pool. At its discretion, the board or Audit Committee may request copies of audit programs and details of audit testing from the auditor.

10.3. Audit Program. The audit program shall include detailed testing of representative samples of the following items:

10.3.1. Timely notification to the administrator of inception of coverage for any individuals added to a high risk pool plan issued prior to April 1, 2017

10.3.2. Eligibility of insureds for coverage as defined in the Act.

10.3.3. Accurate and timely submission of reinsurance claims to the administrator including underlying payments by the carrier(s) to providers;

10.3.4. Accurate determination of amounts paid on reinsurance claims;

10.3.5. Accurate and timely payment of reinsurance premiums;

10.3.6. Accuracy in the carrier's filings and reports to the Director containing (i) the carrier's earned health insurance premium from health benefit plans issued in Idaho and (ii) the number of Idaho residents insured under the carrier's health benefit plans.

10.3.7. Accuracy in the calculation of any assessments to carriers based on premium revenue as reported by the carriers.

10.3.8. Accuracy in the carrier's identification of individuals diagnosed with a high risk medical condition.

10.3.9. Timely notification to the administrator of individuals for whom reinsurance is mandated under the Act.

10.4. Additional Audits. The board shall have the right to conduct such additional audit procedures of carriers and the administrator as it deems appropriate.

10.5. Privileged Information. All information disclosed in the course of the audit shall be considered privileged information by the administrator, the carriers, the auditing firm and the pool.

10.6. Auditor. All audits shall be conducted by a firm of Certified Public Accountants selected by the board. The audit firm must be independent and with no conflicting interests with any carrier, the pool or the Administrator; and the audit examinations must be made in accordance with the Generally Accepted Auditing Standards of the American Institute of Certified Public Accountants.

ARTICLE 11 – ASSESSMENTS

11.1. Initial Capitalization and Interim Assessment. The board shall determine the initial capital needs and may assess each carrier accordingly. The board may, from time to time, make interim assessments on carriers. Interim assessments shall be allowed as offsets to future assessments.

11.2. Net Earnings. Each year, the pool's net earnings shall be determined. Net earnings are earned reinsurance premiums, investment income, premium tax revenue and prior assessments in excess of need, less administrative and investment expenses, incurred claims, expense allowances paid, taxes incurred, and agent/broker commissions earned. If the net earnings are negative (i.e., the pool has operated at a loss); the loss shall be recovered by assessments from the carriers as set forth below.

11.3. Assessment of Carriers

11.3.1. Any net loss for the year shall be recouped by assessments of carriers based on premium earned from all health benefit plans, policies or certificates of coverage for specific disease and hospital confinement indemnity, including reinsurance by way of excess loss and stop loss coverage, and determined in accordance with Section 41-5508, Idaho Code.

11.3.2. If the proceeds of an assessment exceed the actual net loss for any year, the excess shall be used by the board to offset future losses or to reduce pool premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

11.3.3. If the proceeds of an assessment (based upon a good faith estimate of incurred but not reported claims) prove insufficient to offset the actual net loss for any year, such remaining net loss shall be carried forward to the succeeding year and considered in determining pool premium and/or estimated assessments

11.4. Late Payments. Assessments shall be paid when billed. If the assessment is not received by the administrator within thirty (30) days of the billing date, interest will be charged from the billing date at the rate of 1.5% per month. The board may suspend reinsurance rights or recommend the Director suspend or revoke the carrier's certificate of authority if payments are not made in accordance with this Article.

11.5. De Minimis Assessments. Any assessment of less than $500 shall not be billed to a carrier, but will be accumulated as a deferred assessment until the cumulative amount deferred exceeds $500. Any assessment of less than $50 shall be forgiven.

11.6. Assessment Deferral. A carrier may seek from the Director, a deferment from all or part of an assessment imposed by the board. The Director may defer all or part of the assessment of a carrier if the Director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred, the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this Section. The carrier receiving the deferment shall remain liable to the pool for the amount deferred and shall be prohibited from issuing a health benefit plan until such time as it pays the assessments.

ARTICLE 12 – REPORTING REQUIREMENTS

12.1. Information Required by Pool. Unless otherwise specified by the board, the following information shall be required by the pool for reinsured risks:

12.1.1. Copy of the Idaho Individual Application;

12.1.2. Identification of the reinsured individual, and any required authorizations for release of medical information, subrogation, third-party liability, etc.;

12.1.3. Name, date of birth, sex, and the identification number of the individual being reinsured;

12.1.4. Plan anniversary date;

12.1.5. Plan version

12.1.6. Effective date of the individual coverage;

12.1.7. Status code as required by the board; and

12.1.8. Hierarchical condition category (HCC) and the high risk medical code(s) with which the reinsured individual has been diagnosed.

12.1.9. The above information may be changed or additional information may be required by the board.

ARTICLE 13 – FINANCIAL ADMINISTRATION

13.1. Books and Records. The administrator shall maintain the books and records of the pool so that financial statements can be prepared to satisfy the Idaho Insurance Code, as amended. Further, the books shall satisfy any additional requirements as may be deemed necessary to meet the needs of the board, the Department and outside auditors.

13.1.1. The receipt and disbursement of cash by the pool and financial statements shall be prepared on the accrual basis of accounting.

13.1.2. Non-cash transactions shall be recorded when the asset or the liability should be realized by the pool in accordance with generally accepted accounting principles.

13.1.3. Assets and liabilities of the pool, other than cash, shall be accounted for and described in itemized records.

13.1.4. The net balance due to/from the pool shall be calculated for each carrier and confirmed with carriers as deemed appropriate by the board or when requested by the respective carrier. These balances should be supported by a record of each carrier's financial transaction with the pool. These records include:

13.1.4.1. Assessments, if applicable to the particular carriers.

13.1.4.2. Allocated net earnings/losses of the pool based upon the assessments methodology contained in this Plan of Operation.

13.1.4.3. Any adjustments to assessments as explained in this Plan of Operation.

13.1.4.4. The amount of reinsurance premium due to the pool.

13.1.4.5. The amount of reimbursement due from the pool to carriers.

13.1.4.6. Adjustments to the amount due to/from the pool based upon corrections to the carrier submissions.

13.1.4.7. Interest charges due from the carriers for late payment of amounts due to the pool.

13.1.4.8. Such other records as may be required by the board.

13.1.5. The pool shall maintain a general ledger whose balances are used to produce the pool's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

13.2. Handling and Accounting of Assets and Money. Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the board. The administrator shall deposit receipts and make disbursements from these accounts.

13.3. Bank Accounts. All bank accounts/checking accounts shall be established in the name of the Idaho Individual High Risk Reinsurance Pool, and shall be approved by the board. Authorized check signers shall be approved by the board.

13.4. Lines of Credit. All lines of credit shall be established in the name of the Idaho Individual High Risk Reinsurance Pool, and shall be approved by the board. Lines of credit shall be used to meet cash shortfalls.

13.5. Investment Policy. All cash shall be invested in available investment vehicles deemed appropriate by the board.

13.6. Department Reimbursement. Ongoing administrative expenses incurred by the Department solely to support the Idaho Individual High Risk Reinsurance Pool will be presented to the board for reimbursement.

ARTICLE 14 – PENALTIES AND DISPUTE RESOLUTION

14.1. Good Faith and Due Diligence of the Carriers. Given numerous factual determinations and tasks to be performed by carriers relative to their participation in the pool, it is expected that all carriers will exercise the highest degree of good faith and due diligence in all aspects of their relationship with the pool. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

14.2. Errors Related to Reinsurance.

14.2.1. Reinsuring an individual ineligible for reinsurance (initial placement or failure to remove an individual becoming ineligible): Coverage for the individual shall be terminated as of the first date of ineligibility. Claims paid by the pool in excess of premiums received are to be returned to the pool with interest. Premium paid in excess of claims will be refunded without interest. An administrative charge established by the board may be assessed in such situations.

14.2.2. Reinsuring an individual eligible for reinsurance at the incorrect premium rate (failure to use correct rates or to apply correct rates to persons reinsured): Reinsurance premiums for the persons involved shall be recalculated and immediate payment of additional premiums must be made, plus interest and an administrative charge. Excess payments will be refunded without interest subject to the limitation on premium refunds.

14.2.3. Reinsuring incorrect Plan: Premiums will be recalculated on the basis of the correct plan and all additional premiums due will be paid immediately, with interest and the administrative charge. Excess premiums will be refunded without interest subject to the limitation on premium refunds.

14.2.4. Incorrect claim payments or submissions: The claim will be recalculated and any amount due to the pool will be repaid immediately, with interest. Adjustments of claim payments for amounts recovered by the carrier under coordination of benefit, subrogation or similar provision shall not be considered errors for which interest or any administrative charge shall be due.

14.3. Errors Related to Assessments. All carrier errors related to the assessment shall require the immediate payment of additional amounts due plus interest calculated from the date such sum should have been paid, plus an administrative charge as established by the board.

14.4. Errors not Listed. All additional sums due to the pool as a result of errors made by carriers other than those listed above shall be paid immediately, with interest and with the applicable administrative charge.

14.5. Gross Negligence and Intentional Misconduct. If the board determines that the nature or extent of the errors related to reinsurance or otherwise by a particular carrier evidences gross negligence or intentional misconduct, the board may, after notice and a hearing, terminate some or all current reinsurance for the carrier or suspend the right of the carrier to sue the reinsurance mechanism for an appropriate period of time. All such actions shall require the concurrence of the Director before they become effective. The board will ensure, to the extent possible, that the suspension or termination of reinsurance for the carrier shall not adversely affect individuals already insured by the carrier.

14.6. Interest and Administrative Charges. All interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The rate of interest and the administrative charge shall be established by the board and may be waived by the board. Errors reported by carriers within ninety (90) days of their occurrence shall not be subject to interest or any administrative charges.

14.7. Limitation on Premium Refunds. All premium refunds due under this Article shall be limited to a period of twelve (12) months from the date the error was corrected unless otherwise agreed to by the board.

14.8. Carrier Appeal of Disputes to Board. The administrator will act on behalf of the board in attempting to resolve disputes between a carrier and the pool; however, a carrier may request permission to appear before the board at any time, in connection with any dispute with the pool.

ARTICLE 15 – INDEMNIFICATION

15.1. Neither the participation in the pool as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by the Idaho Insurance Code, as amended, shall be the basis of any legal action, criminal or civil liability, or penalty against the pool or any of its reinsuring carriers either jointly or separately.

15.2. To the fullest extent permitted by law, the Idaho Individual Health Reinsurance Pool ("pool") shall 1) indemnify any person against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney fees incurred in connection with the action, suit, or proceeding as they become due and 2) advance expenses incurred or to be incurred by such person in defending a civil, criminal, administrative or investigative action, suit or proceeding, threatened or commenced by reason of or arising out of the fact said person is or was a director, officer, employee, agent or volunteer of the pool, or is or was serving at the request of the pool or the Idaho Department of Insurance as a director, officer, employee, agent or volunteer of another program, committee, subcommittee or commission. Any such indemnification or advancement of expenses shall not be deemed exclusive of any other rights to which such person may be entitled under any law or agreement, or otherwise, both as to action in such person's official capacity and as to action in another capacity while holding such office. Any indemnification or advancement of expenses so granted or paid by the pool shall continue as to a person who has ceased to be a director, officer, employee, agent or volunteer and shall inure to the benefit of the heirs and personal representative of such a person.

15.3. No director, officer, employee, agent or volunteer of the pool shall be liable, and no claim for relief or cause of action of any nature may arise against such person, for any act or omission related to the exercise or performance of such person's powers and duties, unless such act or omission constitutes willful or wanton misconduct or a knowing violation of law.

15.4. The obligations and undertakings set forth herein are for the express benefit of the indemnity and are in consideration of the services rendered and to be rendered by the indemnity. The indemnity is expected and shall be entitled to rely upon the benefit of this provision.

15.5. This indemnification shall not be provided on any matter in which the person is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving willful or wanton misconduct or a knowing violation of law.

ARTICLE 16 – AMENDMENT

16.1. Amendments to this Plan of Operation may be suggested by any carrier and be adopted by the board at any time. Amendments to this Plan of Operation shall be subject to the approval of the Director.

ARTICLE 17 – TERMINATION

17.1. The pool shall continue in existence subject to termination in accordance with the requirements of a law or laws of the State of Idaho or the United States of America. In case of enactment of a law or laws which, in the determination of the board and the Director shall result in the termination of the pool, the pool shall terminate and conclude its affairs in a manner to be determined by the board with the approval of the Director. Any funds or assets of any nature held by the pool following termination and payment of all claims and expenses of the pool shall be distributed to the carriers existing at that time in accordance with the then existing assessment formula.

SCHEDULE A – ELIGIBLE HIGH RISK MEDICAL CONDITIONS

A high risk medical condition is defined for purposes of reinsurance ceding as the following list of HCCs. Each HCC corresponds to a specific list of ICD-10 codes, as identified by HHS. The HCCs, ICD-10 codes and labels in the following table will be applicable for ceding during the 2019 calendar year, and subsequent calendar year as updated by the Board from time-to-time. With Board approval, any codes that are replaced or added by HHS to the HCCs in this table after the Board has approved this table for a calendar year may also be used for ceding. This Schedule is expected to be updated annually to reflect the latest ICD-10 codes to be used for ceding during the applicable year.

ICD-10	*ICD-10 Label*	*MCE Age Condition*	*MCE Sex Condition*
HCC 35: End Stage Liver Disease			
I85.00	Esophageal varices without bleeding		
I85.01	Esophageal varices with bleeding		
I85.10	Secondary esophageal varices without bleeding		
I85.11	Secondary esophageal varices with bleeding		
K70.41	Alcoholic hepatic failure with coma	Age >=15	
K71.11	Toxic liver disease with hepatic necrosis, with coma		
K72.01	Acute and subacute hepatic failure with coma		
K72.10	Chronic hepatic failure without coma		
K72.11	Chronic hepatic failure with coma		
K72.90	Hepatic failure, unspecified without coma		
K72.91	Hepatic failure, unspecified with coma		
K76.6	Portal hypertension		
K76.7	Hepatorenal syndrome		
K76.81	Hepatopulmonary syndrome		
HCC 38: Acute Liver Failure/Disease, Including Neonatal Hepatitis			
A06.4	Amebic liver abscess		
B15.0	Hepatitis A with hepatic coma		
B16.0	Acute hepatitis B with delta-agent with hepatic coma		
B16.2	Acute hepatitis B without delta-agent with hepatic coma		
B17.11	Acute hepatitis C with hepatic coma		
B19.0	Unspecified viral hepatitis with hepatic coma		
B19.11	Unspecified viral hepatitis B with hepatic coma		
B19.21	Unspecified viral hepatitis C with hepatic coma		
K70.10	Alcoholic hepatitis without ascites	Age >=15	
K70.11	Alcoholic hepatitis with ascites	Age >=15	
K72.00	Acute and subacute hepatic failure without coma		
K75.0	Abscess of liver		
K75.1	Phlebitis of portal vein		
K76.2	Central hemorrhagic necrosis of liver		
K76.3	Infarction of liver		
P59.1	Inspissated bile syndrome		
P59.20	Neonatal jaundice from unspecified hepatocellular damage		
P59.29	Neonatal jaundice from other hepatocellular damage		
P78.84	Gestational alloimmune liver disease		
HCC 45: Intestinal Obstruction			
K31.1	Adult hypertrophic pyloric stenosis	Age >=15	
K31.3	Pylorospasm, not elsewhere classified		

ICD-10	*ICD-10 Label*	*MCE Age Condition*	*MCE Sex Condition*
K31.5	Obstruction of duodenum		
K50.012	Crohn's disease of small intestine with intestinal obstruction		
K50.112	Crohn's disease of large intestine with intestinal obstruction		
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction		
K50.912	Crohn's disease, unspecified, with intestinal obstruction		
K51.012	Ulcerative (chronic) pancolitis with intestinal obstruction		
K51.212	Ulcerative (chronic) proctitis with intestinal obstruction		
K51.312	Ulcerative (chronic) rectosigmoiditis with intestinal obstruction		
K51.412	Inflammatory polyps of colon with intestinal obstruction		
K51.512	Left sided colitis with intestinal obstruction		
K51.812	Other ulcerative colitis with intestinal obstruction		
K51.912	Ulcerative colitis, unspecified with intestinal obstruction		
K56.0	Paralytic ileus		
K56.1	Intussusception		
K56.2	Volvulus		
K56.3	Gallstone ileus		
K56.41	Fecal impaction		
K56.49	Other impaction of intestine		
K56.50	Intestinal adhesions [bands], unspecified as to partial versus complete obstruction		
K56.51	Intestinal adhesions [bands], with partial obstruction		
K56.52	Intestinal adhesions [bands] with complete obstruction		
K56.600	Partial intestinal obstruction, unspecified as to cause		
K56.601	Complete intestinal obstruction, unspecified as to cause		
K56.609	Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction		
K56.690	Other partial intestinal obstruction		
K56.691	Other complete intestinal obstruction		
K56.699	Other intestinal obstruction unspecified as to partial versus complete obstruction		
K56.7	Ileus, unspecified		
Q40.0	Congenital hypertrophic pyloric stenosis		
Q41.0	Congenital absence, atresia and stenosis of duodenum		
Q41.1	Congenital absence, atresia and stenosis of jejunum		
Q41.2	Congenital absence, atresia and stenosis of ileum		
Q41.8	Congenital absence, atresia and stenosis of other specified parts of small intestine		
Q41.9	Congenital absence, atresia and stenosis of small intestine, part unspecified		
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula		
Q42.1	Congenital absence, atresia and stenosis of rectum without fistula		
Q42.2	Congenital absence, atresia and stenosis of anus with fistula		
Q42.3	Congenital absence, atresia and stenosis of anus without fistula		
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine		
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified		

ICD-10	*ICD-10 Label*	*MCE Age Condition*	*MCE Sex Condition*
Q43.1	Hirschsprung's disease		
Q43.2	Other congenital functional disorders of colon		
Q43.3	Congenital malformations of intestinal fixation		
HCC 66: Hemophilia			
D66	Hereditary factor VIII deficiency		male
D67	Hereditary factor IX deficiency		male
HCC 118: Multiple Sclerosis			
G35	Multiple sclerosis		
G36.0	Neuromyelitis optica [Devic]		
G37.0	Diffuse sclerosis of central nervous system		
G37.5	Concentric sclerosis [Balo] of central nervous system		
HCC 251: Stem Cell, Including Bone Marrow, Transplant Status/Complications			
D89.810	Acute graft-versus-host disease		
D89.811	Chronic graft-versus-host disease		
D89.812	Acute on chronic graft-versus-host disease		
D89.813	Graft-versus-host disease, unspecified		
T86.00	Unspecified complication of bone marrow transplant		
T86.01	Bone marrow transplant rejection		
T86.02	Bone marrow transplant failure		
T86.03	Bone marrow transplant infection		
T86.09	Other complications of bone marrow transplant		
T86.5	Complications of stem cell transplant		
Z48.290	Encounter for aftercare following bone marrow transplant		
Z94.81	Bone marrow transplant status		
Z94.84	Stem cells transplant status		

SCHEDULE B – REINSURANCE PARAMETERS

Covered claims shall be reimbursed as follows.

Beginning January 1, 2018, and continuing through December 31, 2019:

- Attachment point: $50,000
- Coinsurance rate: fifty percent (50%)
- Maximum annual reinsurance of $250,000

Beginning January 1, 2020, and continuing until such time as specified by the board in accordance with 41-5505(2), Idaho Code:

- Attachment point: $50,000
- Coinsurance rate: sixty percent (60%)
- Maximum annual reinsurance of $250,000