IDAHO

SMALL EMPLOYER

HEALTH REINSURANCE PROGRAM

PLAN OF OPERATION

AMENDED AND RESTATED

EFFECTIVE JANUARY 1, 2023

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PLAN OF OPERATION

ARTICLE 1 - NAME

1.1 The Small Employer Health Reinsurance Program (hereinafter referred to as the "program" or ISEHRP) is an independent public body, corporate and politic. The program performs an essential governmental function in the exercise of powers conferred upon it in Section 41-4711, Idaho Code. Any assessments imposed or collected pursuant to the operation of the program shall at all times be free from taxation of every kind.

ARTICLE 2 - PURPOSE

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

ARTICLE 3 - DEFINITIONS

3.1 The terms used in this Plan of Operations have the same meanings as they are given in Chapter 47, Title 41, Idaho Code, (the "Act"); and are hereby adopted by reference.

ARTICLE 4 - POWERS OF THE PROGRAM

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

ARTICLE 5 - PLAN OF OPERATION

5.1 The program will perform its functions in accordance with the Idaho Insurance Code and this Plan of Operations. The Plan of Operations and any amendments necessary or suitable hereto will assure the fair, reasonable, and equitable administration of the program and provide for the sharing of program gains or losses on an equitable proportionate basis in accordance with the provisions of the Act. 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 program will exercise its powers through a Board of Directors:

6.1.1. 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 on the first day following adjournment of the annual meeting of the year of appointment and expire on the last day of the annual meeting following completion of the term.

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 and on the second Tuesday in August each subsequent year, unless the board, upon at least a thirty (30) calendar day notice, designates some other date or place.

6.10. At each annual meeting 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 program in support of the goals of the Act;

6.10.6. Review the rates for the program benefit plans and reinsurance coverage, benefit plan design and communication programs based on the provisions of the Act;

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

6.10.8. Determine if an assessment is necessary for the proper administration of the program; and

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

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 program.

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 program 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 program 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 program 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 of appropriate reinsurance premium rates, methodologies, rate schedules, rate adjustments, and rate classifications for groups or eligible enrollees reinsured with the program.

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

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

7.1.4. Determine the incurred claim losses of the program, including amounts for incurred but not reported claims.

7.1.5. Recommend assessment methodology and assessments.

7.1.6. 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.

7.2.2. Provide administrative interpretations as to the intent of the Plan of Operation and provide administrative direction on issues referred to it by the board, the administrator, or a carrier. This committee shall provide administrative assistance in communicating the spirit and purpose of the Act.

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 program operations, including proposed contracts and operational practices.

7.3.5. Prepare contracts and legal documents for the program 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 program 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. Compliance Committee. The mission of the Compliance Committee shall include the following items, as well as any other appropriate tasks assigned to it by the board:

7.4.1. Develop uniform programs for an independent auditor to conduct an annual audit, review or compilation of program 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, review or compilation of the program operations.

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

7.4.4. Assist the board on any other audit, review or compilation-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 program.

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 program in accordance with the Idaho Insurance Code and this Plan of Operation.

8.3.3. Establish on behalf of the program, 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 program on a timely basis.

8.3.5. Deposit all cash collected on behalf of the program 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 program.

8.3.8. Keep all accounting, administrative and financial records of the program 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 program 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 program 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 - CARRIER REINSURANCE

9.1. General Rules.

9.1.1. Within sixty (60) days following the initial effective date of coverage, the carrier must send notice to the administrator of the carrier's intent to reinsure an entire group, an individual employee or an eligible dependent. Notice must include all information required by the form adopted by the program and provided by the administrator.

9.1.2. The carrier must submit all initial premium due in accord with the Billing and Payment section of this Article.

9.1.3. Reinsurance shall be effective on the same date the coverage took effect with the carrier.

9.1.4. Claims experience during the sixty (60) day period shall not be used in determining whether to cede to the program.

9.1.5. No change in policy form or any other change to a health benefit plan shall constitute a change in any health benefit plan's initial effective date for any coverage with the same carrier, except:

a. when the health benefit plan or coverage is changed to one for which the carrier's liability is substantially greater; and then only

b. when the carrier cannot deny the improvement in benefits under any Federal or State requirement.

Removal of a rider, which restricts coverage, does not constitute an improvement in benefits which qualifies for a change in any health benefit plan's effective date.

9.1.6. Reinsurance shall only be provided up to the level of the standardized, state-approved health benefit plans purchased by the carrier.

9.1.7. A reinsuring small employer carrier may not notify a small employer, an employee or any other eligible individual or dependent that they have been reinsured with the program.

9.1.8. Each carrier proposing to reinsure an individual or an entire small employer group is responsible for ascertaining and certifying;

a. that the individual or entire small employer group, including all individuals of which the group is composed, are eligible.

b. that the small employer health reinsurance premium rate level payable to the program has been correctly determined.

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

9.1.9. If a carrier has previously withdrawn reinsurance of coverage for any person or an entire small employer group, the same reinsuring carrier cannot again reinsure that person or group so long as that person or group remains insured by that carrier, except:

a. when a state approved health benefit plan or coverage is changed to one for which the carrier's liability is substantially greater; **and then only**

b. when the carrier cannot deny the improvement in the benefits under any Federal or State requirement.

9.1.10. Newborns cannot be reinsured as individuals unless at least one (1) parent is covered by the reinsurance program. All insured newborns, born to covered employees or to covered dependents must be reinsured in order to maintain entire small employer group reinsurance.

9.2. Small Employer & Entire Group Reinsurance Eligibility.

Whether a firm is a small employer is determined upon the application to a carrier for a health benefit plan and re-determined at each subsequent plan anniversary. Plan anniversary for these purposes can be the plan's renewal date provided that determinations based on said date are not made more than once every twelve (12) months.

9.2.1. This determination shall be based on the most recent employer census information which reflects the number of eligible employees, accompanied by a small employer certification of this information, unless the small employer submits other verifiable information to the carrier.

9.2.2. Reinsurance is available only if the small employer satisfies eligibility, contribution and participation requirements specified in the carrier's benefit plan.

9.2.3. Each carrier is responsible for determining whether a firm is a small employer as of the effective date of coverage, for updating that determination as of each

renewal date, and for obtaining information from the small employer to document that determination.

9.2.4. The carrier is also responsible for certifying the above determination to the administrator, if any coverage under a small employer's health benefit plan is to be reinsured.

9.2.5. If a carrier erroneously certifies a firm to be a small employer, any reinsurance of employees of that firm is nullified. Any material statement by a small employer or an employee which falsely certifies as to an individual's eligibility for coverage constitutes cause for termination of reinsurance, without penalty to the carrier. Provided the small employer carrier has acted in good faith, reinsurance shall cease on a prospective basis as of the first day of the next reinsurance month following discovery of the error.

9.2.6. The small employer's health benefit plan must specify the period of full-time employment which must be completed by newly hired eligible employees before coverage starts; provided that such period must be applied uniformly to all eligible employees within a class and determined on a basis without regard to the actual or expected health conditions of eligible employees or dependents.

9.2.7. If a small employer carrier offers coverage to a small employer, it must offer at least the same coverage to all the small employer's eligible employees and dependents. A small employer carrier may not offer coverage limited to certain enrollees in a group, except for allowable exclusions with respect to Late Enrollees.

9.2.8. *Late Enrollee Provisions*

a. For the purpose of determining late enrollee status, the initial enrollment period refers to the enrollee's earliest opportunity to enroll for coverage under any plan sponsored by the small employer with a particular small employer carrier.

b. If coverage is provided for a late enrollee, reinsurance will be available subject to the satisfaction of any preexisting condition limitation provided for in Section 41-4708(3)(a), (b), or (c), Idaho Code, as amended.

9.2.9. Subject to payment of premium, all new eligible employees and dependents must be reinsured within sixty (60) days following the commencement dates of their coverage.

9.2.10. A small employer group must have between two (2) and fifty (50) eligible employees, inclusive, at the effective date of reinsurance.

9.3. Individual Employee Eligibility.

Whether an individual employee from a small employer plan is eligible is determined upon the application to a carrier for a health benefit plan.

9.3.1. A small employer carrier may reinsure an employee or eligible dependent of an employee of a small employer, without reinsuring coverage of any specific dependent of that employee, or may reinsure coverage of a specific dependent, except newborns, without reinsuring coverage of the employee.

9.3.2. There is no automatic reinsurance of any newly enrolled employee or dependent without payment of premium to the program.

9.4. Period of Reinsurance.

9.4.1. Reinsurance for persons insured under small employer health benefit plans will end on the first plan anniversary after a small employer ceases to be a small employer, unless the coverage is continued at the election of the employer and shall continue to apply until such time as the employer fails to renew its current health benefit plan. For persons reinsured as individual employees or dependents of employees, reinsurance may continue as long as coverage remains in effect for the small employer.

9.4.2. A carrier may withdraw a group or individual employee or dependent from reinsurance with the program while the coverage continues to be in effect. Withdrawals will be effective on a plan anniversary.

9.4.3. Reinsurance of an individual's coverage under a small employer's plan ceases at the termination of the individual's status as an eligible employee or dependent (e.g., at retirement or other termination of active employment, divorce of a spouse, or a child's attainment of age nineteen (19) or twenty-three (23) if a full-time student, etc.), except to the extent that coverage continues as required by law. Reinsurance of an individual's coverage under the individual's small employer health benefit plan ceases at the termination of the individual's status as an eligible employee or dependent except to the extent that coverage continues as required by law. If the reinsuring small employer 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.

9.5. Determination of Reinsurance Premium.

9.5.1. Tables of reinsurance premium rates for each of the standardized, state- approved health benefit plans, as determined by the Actuarial Committee, and approved by the board and by the Director, will be communicated to small employer carriers. Separate tables may be prescribed for benefit levels required for entire groups or for individual employee reinsurance.

9.6. Billing and Payment.

9.6.1. Reinsurance bills will be handled on a "self-billed" basis. Monthly, the ceding carrier will provide the administrator with a listing of the individuals reinsured and the premium for each individual and such other information as may be required by the program. The administrator will make any necessary corrections and send the corrected statement to the carrier.

9.6.2. The reinsurance premiums charged by the program for each individual employee will be determined by the table of rates in effect on the effective date of the employee. Changes in rates will take effect thirty (30) 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 health 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 employee or dependent, occasioned by a change in that person's age, shall take effect on the anniversary of the enrollment date which falls on or follows the effective date of the change.

9.6.3. Premiums are determined as of the first (1^{st}) of the month and are due by the twentieth (20^{th}) of the month. Interest on late premiums will be charged at 1.5% per month.

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

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

9.6.6. Reinsurance premium is due monthly to the program regardless of the reinsuring carrier's ability to charge back or collect the premiums. The program has no responsibility for the collection of premiums from small employers.

9.7. Reinsurance Claims.

9.7.1. The program shall indemnify carriers for the covered claims incurred with respect to those whose coverage with the carrier is reinsured with the program as described in the Idaho Insurance Code, as amended, and subject to the following:

9.7.1.1. No reimbursement shall be provided until a deductible and any additional retention (co-insurance) amount, as specified by the Act or amendments as prescribed by the board have been met for services provided during a calendar year.

9.7.1.2. With the Director's approval, the deductible amount, threshold amount, or retention percentage may be changed by the board. Any such change shall take effect on January 1, of the year following adoption of such change by the board.

9.7.1.3. Coverage provided by carriers under other plans reinsured with the program shall be insured up to the lesser of the benefits provided under the other plan or the level of benefits provided in a basic, standard or catastrophic standardized state-approved health benefit plan, for which reinsurance premium was paid.

9.7.1.4. For the purposes of this section, "covered claims" shall mean only such amounts as are actually paid by the carrier for benefits provided for employees reinsured by the program. Covered claims shall not include:

(a) Claim expenses or salaries paid to employees of the carrier who are not providers of health care 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.

9.8. General Claims Requirements.

9.8.1. *Claims Reporting.*

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

9.8.2.1. the small employer's and/or the eligible individual's, employee's or enrollee's identification number;

9.8.2.2. the employee's or eligible dependent's name and social security number;

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

9.8.2.4. the claim incurred dated and paid date;

9.8.2.5. the reinsurance claim amount

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

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

9.8.3. Reinsuring 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 program copies of such reports of investigation as may be requested by the program.

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

9.8.5. Carriers shall use their cost containment programs to control costs on reinsured business to the same extent that they would use such programs on their 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.

9.8.6. The program 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.

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

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

9.8.9. If any payment is made by the program and the carrier is reimbursed by another party for the same expenses, the program 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.

9.8.10. 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 program based on the negotiated reimbursement amount.

9.8.11. 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.

9.8.12. Carriers shall not delay payment of otherwise valid claims due to the transfer of risk to the program.

9.9. Computation of Time Periods. In computing a period of time allowed by this Article 9, 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.

9.10. Notices. All notices and other communications required or permitted by this Article 9 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.

ARTICLE 10 - AUDITING FUNCTIONS

10.1. Annual Audit. Annually, the program will cause an audit to be conducted of the program 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 program fairly present in all material respects, the financial position of the program. Auditors of the program shall also provide the Compliance Committee and the board a report of any reportable conditions or material weaknesses in the internal controls and processes of the program. At its discretion, the board or Compliance 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 of inception of coverage.

10.3.2. Eligibility of individuals and small employer groups 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. .

10.4. 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 program.

10.6. Auditor. All audits shall be conducted by a firm of Certified Public Accountants selected by the board. The firm must be independent and with no conflicting interests with any carrier, the program 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.

10.7. Review or Compilation in Lieu of Audit. In the event that no small employer groups, eligible employees or eligible dependents were reinsured by the program and no reinsurance claims were submitted to or paid by the program during the year, an independent review or compilation may be conducted instead of an audit. All reviews or compilations shall be conducted by a firm of Certified Public Accountants selected by the board. The firm must be independent and with no conflicting interests with any carrier, the program or the Administrator; and the review or compilation must be conducted 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 program's net earnings shall be determined. Net earnings are earned reinsurance premiums, investment income, 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 program 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 41-4711(12)(c)(ii), 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 program 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 program 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 $100 shall not be billed to a carrier, but will be accumulated as a deferred assessment until the cumulative amount deferred exceeds $100. Any assessment of less than $10 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 subsection. The carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

11.7. Transition. Notwithstanding discontinuance of the Individual Health Reinsurance Program under Section 41-4711, Idaho Code, if the proceeds of the small employer and individual health reinsurance program assessments for calendar year 2000 (based upon a good faith estimate of incurred but not reported claims) exceed the actual net loss of the program (considering both individual and small employer reinsurance) for 2000, the excess shall be used by the board to offset future losses and/or to reduce premiums in the

ongoing small employer program; and conversely, if the proceeds of the small employer and individual health reinsurance program assessments for calendar year 2000 (based upon a good faith estimate of incurred but not reported claims) prove insufficient to offset the actual net loss of the program (considering both individual and small employer reinsurance) for 2000, such remaining net loss shall be carried forward to the succeeding year and considered in determining premiums and/or estimated assessments in the ongoing small employer program. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

ARTICLE 12 - REPORTING REQUIREMENTS

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

12.1.1. Copy of the Idaho Small Employer 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. Identification of the reinsured as an employee, spouse, or child;

12.1.5. Employee/dependent name (if different) and social security or identification number, and any required authorizations for release of medical information, subrogation, third-party liability, etc.;

12.1.6. Employer's name, address and zip code, as provided on federal income tax returns.

12.1.7. Plan anniversary date;

12.1.8. Plan version;

12.1.9. Effective date of small employer/employee or dependent coverage;

12.1.10. Status code as required by the board;

12.1.11. Effective date of reinsurance;

12.1.12. Date of applicable employee's employment;

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

12.2. Changes in coverage. Changes in reinsurance coverage require the following information:

12.2.1. The reinsured name and identification number;

12.2.2. Employee/dependent name (if different) and social security or identification number;

12.2.3. Effective date of status change;

12.2.4. Status code for change as required by the board;

12.2.5. Other information required by the board.

ARTICLE 13 - FINANCIAL ADMINISTRATION

13.1. Books and Records. The administrator shall maintain the books and records of the program 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 program 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 program in accordance with generally accepted accounting principles.

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

13.1.4. The net balance due to/from the program 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 program. These records include:

13.1.4.1. Assessments, if applicable to the particular carriers.

13.1.4.2. Allocated net earnings/losses of the program 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 program for risks enrolled in the program.

13.1.4.5. The amount of reimbursement due from the program for claims paid by the carrier for risks previously enrolled in the program.

13.1.4.6. Adjustments to the amount due to/from the program 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 program.

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

13.1.5. The program shall maintain a general ledger whose balances are used to produce the program'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 Small Employer Health Reinsurance Program, 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 Small Employer Health Reinsurance Program, 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 Small Employer Health Reinsurance Program 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 program, 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 program. 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 ineligible small employer, employee, dependent (initial placement or failure to remove an individual becoming ineligible): Coverage

shall be terminated as of the first date of ineligibility. Claims paid by the program in excess of premiums received are to be returned to the program 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 eligible employee or dependent at an 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 program 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 program 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 program; however, a carrier may request permission to appear before the board at any time, in connection with any dispute with the program.

ARTICLE 15 - INDEMNIFICATION

15.1. Neither the participation in the program 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 program or any of its reinsuring carriers either jointly or separately.

15.2. To the fullest extent permitted by law, the Idaho Small Employer Health Reinsurance Program ("program") 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 program, or is or was serving at the request of the program 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 program 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 program 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 program 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 program, the program 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 program following termination and payment of all claims and expenses of the program shall be distributed to the carriers existing at that time in accordance with the then existing assessment formula.

ARTICLE 18 - AGENTS AND BROKERS

18.1. Each carrier shall utilize the same procedures, for appointment of and commission payment to, agents or brokers for health benefit plans subject to the Idaho Insurance Code as it does with non-subject plans. If the small employer utilizes a broker, the carrier shall provide reasonable compensation to a licensed broker, as a small employer health care commission. If circumstances warrant, a carrier may petition the Director for relief from having to issue coverage brought to it by a particular agent or broker. Any carrier soliciting the standardized state-approved small employer health insurance plans at a commission rate which is lower than the rate paid for non-guaranteed issue plans, will be deemed to be in violation of Idaho Code 41-4716(4) and would be subject to the provisions of Idaho Code 41-4716(9).

18.2. If a carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative marketing or other services related to the offering of health benefit plans to small employers in this state, the third party administrator shall be subject to the provisions of this section as if it were a carrier.