

(i) the Administrator's proven ability to provide health insurance coverage to individuals;

(ii) the efficiency and timeliness of the Administrator's claim processing procedures;

(iii) an estimate of total charges for administering the Plan;

(iv) the Administrator's proven ability to apply effective cost containment programs and procedures; and

(v) the financial condition and stability of the Administrator.

(b) (1) The Administrator shall serve for a period of time specified in its contract with the Plan subject to removal for cause and any other terms, conditions, and limitations contained in the contract.

(2) THE CONTRACT BETWEEN THE BOARD AND THE ADMINISTRATOR SHALL REQUIRE THE ADMINISTRATOR TO COMPLY WITH THE PROVISIONS OF THIS SUBTITLE TO WHICH THE PLAN IS SUBJECT.

(c) The Administrator shall perform functions relating to the Plan as required by the Board, including:

- (1) determination of eligibility;
- (2) data collection;
- (3) case management;
- (4) financial tracking and reporting;
- (5) payment of claims; and
- (6) premium billing.

(d) (1) Each year, the Plan Administrator shall submit to the Commissioner an accounting of medical claims incurred, administrative expenses, and premiums collected.

(2) Plan losses shall be certified by the Commissioner in accordance with paragraph (3) of this subsection and returned to the Administrator by the Board.

(3) Administrative expenses and fees shall be paid as provided in the Administrator's contract with the Board.