INSURANCE

CHAPTER 246

HOUSE BILL NO. 1287

(Representatives Svedjan, Price)
(Senators Lips, Thane)

LIMITED BENEFIT POLICY DEFINITION AND APPLICATION

AN ACT to create and enact a new section to title 26.1 of the North Dakota Century Code, relating to the definition of limited benefit policy and the circumstances under which statutes affect those types of policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to title 26.1 of the North Dakota Century Code is created and enacted as follows:

Definition of limited benefit policy - Application. In this title, "limited benefit policy" means a policy or certificate issued under a group insurance policy that provides coverage for accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance, or automobile medical payment or no-fault insurance; or a policy or certificate of specified disease, hospital confinement indemnity, or any other type of limited benefit health insurance. Any statute that becomes effective after January 1, 1997, and affects accident and health insurance, or any hospital, medical, or major medical policy, whether issued on a group or individual basis, does not apply to a limited benefit policy unless the statute specifically identifies application to a limited benefit policy.

Approved March 26, 1997
Filed March 26, 1997

CHAPTER 247

SENATE BILL NO. 2132

(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE INVESTMENTS, SUPPLEMENTS, AND ENDORSEMENTS

AN ACT to create and enact a new subsection to section 26.1-05-19, relating to insurance company investments; and to amend and reenact subsection 6 of section 26.1-03-17, subsection 4 of section 26.1-36.1-01, subsection 4 of section 26.1-36.1-05, and section 26.1-44-05 of the North Dakota Century Code, relating to an annual insurance premium tax filing fee, medicare supplement insurance, and endorsement of surplus lines insurance policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 6 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

6. ~~An annual filing fee in the amount of two hundred dollars must be collected by the commissioner from each entity subject to this section. This fee must be reduced by an amount equal to the net tax due under subsections 1 and 2.~~ In lieu of the tax required by subsection 1, the commissioner shall collect from each entity subject to this section an annual filing fee in the amount of two hundred dollars, provided the total tax liability of the entity pursuant to subsection 1 is less than two hundred dollars. No annual filing fee is due or may be collected from an entity if its total tax liability pursuant to subsection 1 is in excess of two hundred dollars. The annual filing fee may be reduced by any credits available pursuant to subsections 2 and 5.

SECTION 2. A new subsection to section 26.1-05-19 of the North Dakota Century Code is created and enacted as follows:

Loans, securities, or investments in addition to those permitted in this section, whether or not the loans, securities, or investments qualify or are permitted as legal investments under its charter, or under other provisions of this section or under other provisions of the laws of this state. The aggregate admitted value of the company's investments under this section may not at any one time exceed either seven percent of the company's admitted assets, or the amount equal to the company's capital and surplus in excess of the minimum capital and surplus required by law, whichever is less.

SECTION 3. AMENDMENT. Subsection 4 of section 26.1-36.1-01 of the North Dakota Century Code is amended and reenacted as follows:

4. "Medicare supplement policy" means a group or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization or preferred provider organization, other than a policy issued pursuant

to a contract under section 1876 ~~or 1833~~ of the federal Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under a demonstration project ~~authorized pursuant to amendments to the federal Social Security Act~~ specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

SECTION 4. AMENDMENT. Subsection 4 of section 26.1-36.1-05 of the North Dakota Century Code is amended and reenacted as follows:

4. The commissioner may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for medicare, other than:

   a. Medicare supplement policies~~.~~ ; or

   b. Disability income policies.

   ~~c. Basic, catastrophic, or major medical expense policies.~~

   ~~d. Single premium, nonrenewable policies.~~

SECTION 5. AMENDMENT. Section 26.1-44-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-44-05. Endorsement of policy. Every policy issued under this chapter must be endorsed "THIS POLICY IS ISSUED PURSUANT TO THE NORTH DAKOTA SURPLUS LINES INSURANCE STATUTE UNDER THE SURPLUS LINES BROKER'S LICENSE ~~NO.~~ OF _____. THE INSURER IS A QUALIFIED SURPLUS LINES INSURER, BUT IS NOT OTHERWISE LICENSED BY THE STATE OF NORTH DAKOTA AND DOES NOT PARTICIPATE IN THE NORTH DAKOTA INSURANCE GUARANTY ASSOCIATION." The surplus lines insurance broker shall properly complete the endorsement by typing or printing the broker's full name in the space provided and shall sign and date the endorsement.

Approved April 10, 1997
Filed April 10, 1997

CHAPTER 248

HOUSE BILL NO. 1418

(Representatives Boucher, Callahan, Jensen)
(Senators Mutzenberger, Nalewaja, O'Connell)

HEALTH CARE PROVIDER AND PATIENT COMMUNICATIONS

AN ACT to create and enact three new subsections to section 26.1-04-03 of the North Dakota Century Code, relating to the restriction or interference with medical communications between health care providers and patients and unfair indemnification provisions in contracts with health care providers; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-04-03 of the North Dakota Century Code is created and enacted as follows:

As used in sections 2 and 3 of this Act, unless the context otherwise requires:

a. "Entity" includes a third-party administrator or other person with responsibility for contracts with health care providers under a health plan.

b. "Health care provider" means a person that delivers, administers, or supervises health care products or services, for profit or otherwise, in the ordinary course of business or professional practice.

c. "Health plan" means any public or private plan or arrangement that provides or pays the cost of health benefits, including any organization of health care providers that furnishes health services under a contract or agreement with this type of plan.

d. "Medical communication" means any communication, other than a knowing and willful misrepresentation, made by a health care provider to a patient regarding the health care needs or treatment options of the patient and the applicability of the health plan to the patient's needs or treatment. The term includes communications concerning:

(1) Tests, consultations, and treatment options;

(2) Risks or benefits associated with tests, consultations, and options;

(3) Variation in experience, quality, or outcome among any health care providers or health care facilities providing any medical service;

(4) The process, basis, or standard used by an entity to determine whether to authorize or deny health care services or benefits; and

(5) Financial incentives or disincentives based on service utilization provided by an entity to a health care provider.

e. "Patient" includes a former, current, or prospective patient or the guardian or legal representative of any former, current, or prospective patient.

SECTION 2. A new subsection to section 26.1-04-03 of the North Dakota Century Code is created and enacted as follows:

a. Interference with certain medical communications. An entity offering a health plan may not restrict or interfere with any medical communication and may not take any of the following actions against a health care provider solely on the basis of a medical communication:

(1) Refusal to contract with the health care provider;

(2) Termination of or refusal to renew a contract with the health care provider;

(3) Refusal to refer patients to or allow others to refer patients to the health care provider; or

(4) Refusal to compensate the health care provider for covered services that are medically necessary.

b. This subsection does not prohibit an entity from enforcing, as part of a contract or agreement to which a health care provider is a party, any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in and cooperate with all programs, policies, and procedures developed or operated by a health plan to assure, review, or improve the quality and effective utilization of health care services, if the utilization is according to guidelines or protocols that are based on clinical or scientific evidence and only if the guidelines or protocols under the utilization do not prohibit or restrict medical communications between providers and their patients.

SECTION 3. A new subsection to section 26.1-04-03 of the North Dakota Century Code is created and enacted as follows:

Unfair indemnification. A contract between an entity and a health care provider may not require the health care provider to indemnify the entity for the entity's negligence, willful misconduct, or breach of contract, and may not require a health care provider as a condition of participation to waive any right to seek legal redress against the entity. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void.

Approved April 3, 1997
Filed April 3, 1997

CHAPTER 249

SENATE BILL NO. 2236

(Senators Tallackson, Lips)
(Representatives Carlson, Wald)

INSURANCE COMPANY SETOFFS

AN ACT to amend and reenact section 26.1-06.1-29 of the North Dakota Century Code, relating to insurance company setoff in liquidation or rehabilitation; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-06.1-29 of the North Dakota Century Code is amended and reenacted as follows:

26.1-06.1-29. Setoffs.

1. Mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this chapter, must be set off and the balance only may be allowed or paid, except as provided in ~~subsections~~ subsection 2~~, 3, and 4~~ and section 26.1-06.1-32.

2. No setoff may be allowed in favor of any person where:

   a. The obligation of the insurer to the person would not at the date of filing of a petition for ~~liquidation~~ receivership entitle the person to share as a claimant in the assets of the insurer;

   b. The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

   c. The obligation of the insurer is owed to an affiliate of the person, or any other entity or association other than the person;

   d. The obligation of the person is owed to an affiliate of the insurer, or any other entity or association other than the insurer;

   e. The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

   f. The obligations between the person and the insurer arise from business ~~which is both ceded to and assumed from the insurer except that the rehabilitator may, with regard to such business, allow certain setoffs in rehabilitation if the liquidator finds the allowance of the setoffs appropriate~~ where either the person or the insurer has assumed risks and obligations from the other party and has ceded back to that party substantially the same risks and obligations.

3. ~~The liquidator shall provide persons that assumed business from the insurer with accounting statements identifying debts which are currently due and payable. Such persons may set off against such debts only mutual credits which are currently due and payable by the insurer to such persons for the period covered by the accounting statement.~~

~~4.~~ ~~A person that ceded business to the insurer may set off debts due the insurer against only those mutual credits which the person has paid or which have been allowed in the insurer's delinquency proceeding.~~

~~5.~~ ~~Notwithstanding the foregoing, a setoff of sums due on obligations in the nature of those set forth in subdivision f of subsection 2 must be allowed for those sums accruing from business written where the contracts were entered into, renewed, or extended with the express written approval of the commissioner of insurance of the state of domicile of the now insolvent insurer, when in the judgment of such commissioner it was necessary to provide reinsurance in order to prevent or mitigate a threatened impairment or insolvency of a domiciliary insurer in connection with the exercise of the commissioner's regulatory responsibilities.~~

~~6.~~ These amendments ~~must~~ become effective ~~six months~~ from the date of enactment and ~~must~~ apply to all contracts entered into, renewed, extended, or amended on or after that date, and to debts or credits arising from any business written or transactions occurring after the effective date pursuant to any such contract ~~including those in existence prior to the effective date, and must supersede any agreements or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer~~. For purposes of this section, any change in the terms of, or consideration for, any such contract ~~must be~~ is deemed an amendment.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

Approved March 20, 1997
Filed March 20, 1997

CHAPTER 250

SENATE BILL NO. 2310
(Senator Lips)

INSURANCE COMPANY INSOLVENCY DISTRIBUTION PRIORITIES

AN ACT to amend and reenact section 26.1-06.1-41 of the North Dakota Century Code, relating to priority of distributions in insurance company insolvencies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-06.1-41 of the North Dakota Century Code is amended and reenacted as follows:

26.1-06.1-41. Priority of distribution. The priority of distribution of claims from the insurer's estate must be in accordance with the order in which each class of claims is herein set forth. Every claim in each class must be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses may be established within any class. The order of distribution of claims must be:

1. Class 1. The costs and expenses of administration during rehabilitation and liquidation, including the following:

   a. The actual and necessary costs of preserving or recovering the assets of the insurer;

   b. Compensation for all authorized services rendered in the rehabilitation and liquidation;

   c. Any necessary filing fees;

   d. The fees and mileage payable to witnesses;

   e. Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation; and

   f. The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

2. Class 2. ~~Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for service performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors are not entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority must be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.~~ All claims under policies including such claims of the federal or any state or local government for losses incurred, ("loss claims")

including third-party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values must be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits, or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to employees may be treated as a gratuity.

3. Class 3. ~~All claims under policies including such claims of the federal or any state or local government for losses incurred, ("loss claims") including third-party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values must be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits, or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to employees may be treated as a gratuity.~~ Claims of the federal government not included in class 2.

4. Class 4. ~~Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors including claims of ceding and assuming companies in their capacity as such.~~ Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors are not entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority must be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

5. Class 5. ~~Claims of the federal or any state or local government except those under class 3 above. Claims, including those of any governmental body for a penalty or forfeiture, may be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims must be postponed to the class of claims under subsection 8.~~ Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors including claims of ceding and assuming companies in their capacity as such.

6. Class 6. ~~Claims filed late or any other claims other than claims under subsections 7 and 8.~~ Claims of any state or local government except those paid under class 2. Claims, including those of any state or local governmental body for a penalty or forfeiture, may be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose,

with reasonable and actual costs occasioned thereby. The remainder of the claims must be postponed to the class of claims under subsection 9.

7. Class 7. ~~Surplus or contribution notes, or similar obligations, and premium funds on assessable policies. Payments to members of domestic mutual insurance companies must be limited in accordance with law.~~ Claims filed late or any other claims other than claims under subsections 8 and 9.

8. Class 8. ~~The claims of shareholders or other owners in their capacity as shareholders.~~ Surplus or contribution notes, or similar obligations, and premium funds on assessable policies. Payment to member of domestic mutual insurance companies must be limited in accordance with law.

9. Class 9. The claims of shareholders or other owners in their capacity as shareholders.

If any provision of this section or the application of any provision of this section to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section, and to this end the provisions are severable.

Approved March 21, 1997
Filed March 21, 1997

CHAPTER 251

HOUSE BILL NO. 1168

(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

HEALTH INSURANCE COVERAGE REQUIREMENTS

AN ACT to create and enact section 26.1-36.4-03.1 of the North Dakota Century Code, relating to preexisting condition provisions; to amend and reenact sections 26.1-08-01, 26.1-08-04, 26.1-08-06, 26.1-08-06.1, 26.1-08-07, 26.1-08-12, subsection 3 of section 26.1-08-13, sections 26.1-36.3-01, 26.1-36.3-04, 26.1-36.3-05, 26.1-36.3-06, subsection 1 of section 26.1-36.3-11, sections 26.1-36.4-02, 26.1-36.4-03, 26.1-36.4-04, and 26.1-36.4-05 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota, small group health insurance, and individual health insurance; to repeal section 26.1-08-05 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota; to provide for application; to provide an effective date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[1] **SECTION 1. AMENDMENT.** Section 26.1-08-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Association" means the association created by section 26.1-08-03.

2. "Association plan" means insurance policy coverage offered by the association through the lead carrier.

3. "Association plan premium" means the charge for membership in the association plan based on the benefits provided in section ~~26.1-08-05~~ ~~or~~ 26.1-08-06 and determined pursuant to section 26.1-08-08.

4. "Eligible person" means ~~an~~ either:

   a. An individual who has been a resident of this state for a period of six months and meets the enrollment requirements of section 26.1-08-12~~.~~; or

   b. An individual who:

      (1) Is currently a resident of this state;

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[1] Section 26.1-08-01 was also amended by section 17 of Senate Bill No. 2046, chapter 51.

(2) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01, the most recent of which is coverage under a group health benefit plan, governmental plan, or church plan, as those terms are defined in section 26.1-36.3-01;

(3) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;

(4) Is not eligible for coverage under a group health benefit plan as that term is defined in section 26.1-36.3-01, medicare, or medicaid;

(5) Does not have any other health insurance coverage;

(6) Has not had the most recent qualifying previous coverage described in paragraph 2 terminated for nonpayment of premiums or fraud; and

(7) If offered the option, has elected continuation coverage under the Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage was exhausted.

5. "Health benefits" means benefits offered on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible person, chiropractic care.

6. ~~"Insurance company" means a company or organization operating pursuant to chapter 26.1-17, 26.1-18, or 26.1-36 and offering or selling accident and health insurance policies or health care or health service contracts. The term does not include a health service corporation operating under chapter 26.1-17 which does not write hospital or medical service contracts.~~ "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization selling group or individual hospital, medical, surgical, or major medical coverage.

7. "Lead carrier" means the insurance company selected by the association to administer the association plan.

8. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of individual policies or coverage under a nonprofit health service plan.

9. "Policy" means insurance, health care plan, health benefit plan as defined in section 26.1-36.3-01, or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage which is (a) limited to disability or income protection coverage, (b) automobile medical payment coverage, (c) supplemental to liability insurance, (d) designed solely to provide payment on a per diem basis, daily indemnity, or non-expense-incurred basis, or (e) credit accident and health insurance.

10. "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by section

~~26.1-08-05,~~ 26.1-08-06 for a qualified comprehensive plan, or section 26.1-08-06.1 for a qualified medicare supplement plan, or ~~the actuarial equivalent of those benefits~~ other plan developed by the board and certified by the commissioner as complying with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

SECTION 2. AMENDMENT. Section 26.1-08-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-04. ~~Minimum benefits of association~~ Association plan. The association ~~through its plan~~ shall offer ~~policies that provide at least the benefits of a number one and two qualified plan A and qualified plan B and a qualified medicare extended plan~~ "qualified plans" as defined in section 26.1-08-01.

SECTION 3. AMENDMENT. Section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06. Minimum benefits of a qualified comprehensive plan ~~B~~.

1. A plan of health coverage is a ~~number two~~ qualified comprehensive plan ~~B~~ if it otherwise meets the requirements established by chapter 26.1-36, and the other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

   a. The minimum benefits for covered individuals must, subject to ~~this subdivision~~ subsection 2, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which must not be less than five hundred dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than one million dollars.

   b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

      (1) Hospital services.

      (2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

      (3) Drugs requiring a physician's prescription.

      (4) Services of a nursing home for not more than one hundred twenty days in a year if the services commence within fourteen days following confinement of at least three days in a hospital for the same condition.

      (5) Service of a home health agency up to a maximum ~~of one hundred eighty~~ two hundred seventy visits per year.

      (6) Use of radium or other radioactive materials.

(7) Oxygen.

(8) Anesthetics.

(9) Prostheses.

(10) Rental or purchase, as appropriate, of durable medical equipment.

(11) Diagnostic X-rays and laboratory tests.

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(13) Services of a physical therapist.

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(15) Substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.

c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include:

(1) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another accident and health insurance policy or medicare.

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(3) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other

health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(7) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(8) Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

2. ~~A plan of health coverage is a number one qualified plan B if it meets the requirements established by the laws of this state and provides for the payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which must not be less than one thousand dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than one million dollars~~ A qualified comprehensive plan also must offer the eligible person the choice of an annual deductible of not less than one thousand dollars per person instead of that provided in subdivision a of subsection 1.

SECTION 4. AMENDMENT. Section 26.1-08-06.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06.1. ~~Minimum benefits of a qualified~~ Qualified medicare ~~extended~~ supplement plan. ~~A qualified plan of health coverage must be established for eligible persons who are enrolled under title 1, part 1 of Public Law 89-97 and amendments thereto (Health Insurance for the Aged Act), known as medicare. The plan of health care coverage must supplement medicare part A and medicare part B and must provide for benefits consisting of that portion of medicare eligible expenses which are not paid by medicare part A and medicare part B. The plan of health coverage must provide benefits for medicare deductible and coinsurance amounts for medicare eligible expenses to the extent recognized as reasonable by medicare part A and medicare part B. No benefits may be provided for expenses that are not medicare eligible expenses.~~ A qualified medicare supplement plan is a medicare supplement plan F. This plan is available to individuals who are eligible for medicare by reason of age or disability.

SECTION 5. AMENDMENT. Section 26.1-08-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-07. ~~Certification of qualified~~ Approval of plans. ~~Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of this chapter, the commissioner shall make a determination within ninety days as to whether the plan is qualified. All plans of health coverage must be labeled as "qualified plan A", "qualified plan B", or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans must indicate whether they are number one or two coverage plans.~~ The association or the lead carrier shall file with the commissioner all plans to be offered

under this chapter. The commissioner shall approve or disapprove any form within sixty days of receipt.

SECTION 6. AMENDMENT. Section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-12. Enrollment by eligible person.

1. The association plan must be open for enrollment by eligible persons. A person is eligible and may enroll in the plan by submission of an application to the lead carrier. The application must provide:

   a. The name, address, and age of the applicant, and length of applicant's residence in this state.

   b. The name, address, and age of spouse and children, if any, if they are to be insured.

   c. ~~Written~~ For an "eligible person" under subdivision a of subsection 4 of section 26.1-08-01, written evidence that the applicant has been rejected for accident and health insurance, or that restrictive riders or a preexisting conditions limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least one insurance company within six months of the date of the application.

   d. A designation of coverage desired.

2. Within thirty days of receipt of the application, the lead carrier shall either reject the application for failing to comply with the requirements of subsection 1 or forward the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt of the first month's association plan premium, and is retroactive to the date of the application, if the applicant otherwise complies with this chapter.

3. An eligible person may not purchase more than one policy from the association plan.

4. A person who obtains coverage pursuant to this section may not be covered for maternity during the first two hundred seventy days or any other preexisting condition during the first one hundred eighty days of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the date of the application. Any person with coverage through the association plan due to a catastrophic condition or major illness who is also pregnant at the time of application is eligible for maternity benefits after the first one hundred eight days of coverage. This subsection does not apply to a person receiving nonelective procedures who has lost dependent status under a parent's or guardian's policy that has been in effect for the twelve-month period immediately preceding the filing of an application or to a person who is treated by nonelective procedures for a congenital or genetic disease. No preexisting condition exclusion or waiting period may be imposed under this subsection, or in the terms of the coverage obtained under this chapter, on an "eligible person" under subdivision b of subsection 4 of section 26.1-08-01. For an "eligible person" under subdivision a of subsection 4 of section 26.1-08-01, any

preexisting condition exclusion must be reduced by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06.

SECTION 7. AMENDMENT. Subsection 3 of section 26.1-08-13 of the North Dakota Century Code is amended and reenacted as follows:

3. When the lifetime maximum benefit amount has been reached under ~~subsection 2 of section 26.1-08-05 or~~ subdivision a of subsection ~~2~~ 1 of section 26.1-08-06.

SECTION 8. AMENDMENT. Section 26.1-36.3-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-01. Definitions. As used in this chapter and section 26.1-36-37.2, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the commissioner of insurance, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

3. "Association" means, with respect to health insurance coverage offered in this state, an association that:

   a. Has been actively in existence for at least five years;

   b. Has been formed and maintained in good faith for purposes other than obtaining insurance;

   c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee or dependent of an employee;

   d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member; and

   e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

4. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

~~4.~~ 5. "Basic health benefit plan" means a lower cost health benefit plan developed under section 26.1-36.3-08.

~~5.~~ 6. "Board" means the board of directors of the program established under section 26.1-36.3-07.

~~6. "Carrier" means any entity that provides health insurance in this state. The term includes an insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.~~

7. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.

8. "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

9. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.

~~9.~~ 10. "Committee" means the health benefit plan committee created under section 26.1-36.3-08.

~~10.~~ 11. "Control" is as defined in section 26.1-10-01.

~~11.~~ 12. "Dependent" means a spouse, an unmarried child, including a dependent of an unmarried child, under the age of twenty-two, an unmarried child who is a full-time student under the age of twenty-six and who is financially dependent upon the enrollee, and an unmarried child, including a dependent of an unmarried child, of any age who is medically certified as disabled and dependent upon the enrollee as set forth in section 26.1-36-22.

~~12.~~ 13. "Eligible employee" means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

~~13.~~ 14. "Enrollee" means a person covered under a small employer health benefit plan.

~~14.~~ 15. "Established geographic service area" means a geographic area, as approved by the commissioner of insurance and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

16. "Governmental plan" means an employee welfare benefit plan as defined in section 3(32) of the Employee Retirement Income Security Act of

1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.

17. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this Act:

a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, must be treated as an employee welfare benefit plan which is a group health benefit plan;

b. In the case of a group health benefit plan, the term "employer" also includes the partnership in relationship to any partner; and

c. In the case of a group health benefit plan, the term "participant" also includes:

(1) In connection with a group health benefit plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(2) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive benefits under the plan or the beneficiaries may be eligible to receive any benefit.

~~15.~~ 18. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract. ~~The term does not include accident only, credit, dental, vision, medicare supplement, long term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.~~

b. "Health benefit plan" does not include one or more, or any combination of, the following:

(1) Coverage only for accident, or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance.

c. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Such other similar, limited benefits as are specified in federal regulations.

d. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits, and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and

(3) Similar supplemental coverage provided under a group health plan.

~~b.~~ f. ~~"Health benefit plan" does not include~~ A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance~~, if the carrier offering that policy or certificate~~ shall comply with the following:

(1) ~~Files~~ File with the commissioner of insurance on or before March first of each year a certification that contains:

(a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.

(2) When the policy or certificate is offered for the first time in this state on or after August 1, 1993, files with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

19. "Health carrier" or carrier means any entity that provides health insurance in this state. For purposes of this chapter, health carrier includes an insurance company, a prepaid limited health service corporation, a fraternal benefit society, a health maintenance organization, nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

20. "Health status-related factor" means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including condition arising out of acts of domestic violence; or

h. Disability.

~~16.~~ 21. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

~~17.~~ 22. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll

under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:

a. The individual:

(1) Was covered under qualifying previous coverage at the time of the initial enrollment;

(2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and

(3) Requests enrollment within ~~ninety~~ sixty-three days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

d. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.

23. "Medical care" means amounts paid for:

a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in subdivision a; and

c. Insurance covering medical care referred to in subdivisions a and b.

24. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

~~18.~~ 25. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

~~19.~~ 26. "Plan of operation" means the plan of operation of the program established under section 26.1-36.3-07.

27. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~20.~~ 28. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~21.~~ 29. "Producer" means insurance agent or insurance broker.

~~22.~~ 30. "Program" means the state small employer carrier reinsurance program created under section 26.1-36.3-07.

~~23.~~ 31. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under ~~one or more~~ any of the following:

~~a. Medicare, medicaid, civilian health and medical program for uniformed services, Indian health services program, or any other similar publicly sponsored program.~~

~~b. A health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.~~

~~c. An individual health insurance policy, including coverage issued by a health maintenance organization, nonprofit health service corporation, and fraternal benefit society that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least one year.~~

a. A group health benefit plan;

b. A health benefit plan;

c. Medicare;

d. Medicaid;

e. Civilian health and medical program for uniformed services;

f. A medical care program of the Indian health service or of a tribal organization;

g. A state health benefit risk pool, including coverage issued under chapter 26.1-08;

h. A health plan offered under 5 U.S.C. 89;

i. A public health plan as defined in federal regulations; and

j. A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)].

The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan" under subsection 18.

~~24.~~ 32. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~25.~~ 33. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.

~~26.~~ 34. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.

~~27.~~ 35. "Small employer" means ~~any person that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least three, but no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, must be considered one employer~~, in connection with a group health plan with respect to a calendar and a plan year, an employer who employed an average of at least two but not more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

~~28.~~ 36. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

~~29.~~ 37. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.

SECTION 9. AMENDMENT. Section 26.1-36.3-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-04. Restrictions relating to premium rates.

1. This section only applies to a health benefit plan offered by a small employer who employed an average of at least two but not more than twenty-five eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

2. Premium rates for health benefit plans subject to this ~~chapter~~ section and section 26.1-36-37.2 are subject to the following:

   a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than fifteen percent.

   b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the

same or similar coverage, or the rates that could be charged to the employers under the rating system for that class of business, may not vary from the index rate by more than twenty percent of the index rate.

c. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(2) Any adjustment due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; however, the adjustment may not exceed fifteen percent annually and must be adjusted pro rata for rating periods of less than one year; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

d. Adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents. Premium rates charged for a health benefit plan may not vary by a ratio of greater than four to one after January 1, 1997. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

e. Premium rates for health benefit plans must comply with the requirements of this section notwithstanding any assessment paid or payable by a small employer carrier pursuant to section 26.1-36.3-07.

f. A small employer carrier may utilize industry as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

g. In the case of health benefit plans delivered or issued for delivery before August 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions a and b ~~of~~ ~~subsection~~ ~~1~~ for a period of three years following August 1, 1993. Under this subdivision, the percentage increase in the premium rate charged to

a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

h. (1) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(2) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

i. For the purposes of this subsection, a health benefit plan that uses a restricted provider network may not be considered similar coverage to a health benefit plan that does not use a restricted provider network, if the use of the restricted provider network results in substantial differences in claims costs.

j. A small employer carrier may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size, without prior approval of the commissioner. Gender may not be used as a case characteristic after January 1, 1996.

k. The commissioner shall adopt rules to:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(2) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(3) Otherwise implement this section.

~~2.~~ 3. A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage.

~~3.~~ 4. The commissioner may suspend for a specified period the application of subdivision a of subsection ~~1~~ 2 as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the small employer carrier or, with the prior approval of the committee established pursuant to section 26.1-36.3-08, that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

~~4.~~ 5. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

a. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

b. The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

c. The provisions relating to renewability of policies and contracts; and

d. The provisions relating to any preexisting condition exclusion.

~~5.~~ 6. a. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

b. Each small employer carrier shall file with the commissioner on or before March fifteenth of each year an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification must be in a form and manner and contain information specified by the commissioner. The small employer carrier shall retain a copy of the certification at the carrier's principal place of business.

c. A small employer carrier shall make the information and documentation described in subdivision a of this subsection available to the commissioner upon request. Except in cases of violations of this chapter and section 26.1-36-37.2, the information

is proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

SECTION 10. AMENDMENT. Section 26.1-36.3-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-05. Renewability of coverage.

1. A health benefit plan subject to this chapter and section 26.1-36-37.2 must be renewable with respect to all eligible employees and dependents, at the option of the small employer, except for any of the following:

   a. ~~Nonpayment of the required premiums.~~ The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments.

   b. ~~Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives.~~ The plan sponsor or small employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage.

   c. Noncompliance with the carrier's minimum participation requirements.

   d. Noncompliance with the carrier's employer contribution requirements.

   ~~e. Repeated misuse of a provider network provision.~~

   ~~f. The small employer carrier electing to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In that case the carrier shall:~~

      ~~(1) Provide advance notice of its decision not to renew to the commissioner in each state in which it is licensed; and~~

      ~~(2) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under this paragraph must be provided at least three working days prior to the notice to the affected small employers.~~

   e. A decision by the small employer carrier to discontinue offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the carrier in that market only if the carrier:

(1) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured individual is known to reside at least ninety days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries;

(3) Offers to each plan sponsor provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the carrier to employers in the state; and

(4) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under paragraph 3, the carrier acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

f. A decision by the small employer carrier to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery to small employers in this state. In such a case, the carrier shall:

(1) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provide notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subdivision shall be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries; and

(3) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and not renew coverage under any health benefit plan issued to a small employer.

g. In the case of health benefit plans that are made available in the small employer market only through one or more associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

~~g.~~ h. The commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations. In this case the commissioner shall assist affected small employers in finding replacement coverage.

2. A small employer carrier that elects not to renew a health benefit plan under subdivision f of subsection 1 may not write new business in the small employer market in this state for a period of five years from the date of notice to the commissioner.

3. In the case of a small employer carrier doing business in one established geographic service area of the state, this section only applies to the carrier's operations in that service area.

4. A small employer carrier offering through a network plan may not be required to offer coverage or accept applications pursuant to subsection 1 or 2 in the case of the following:

   a. To an eligible person who no longer resides, lives, or works in the service area, or in an area for which the carrier is authorized to do business, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor; or

   b. To a small employer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the carrier, or the area for which the carrier is authorized to do business.

5. At the time of coverage renewal, a health insurance carrier may modify the health insurance coverage for a product offered to a group health plan, if for coverage that is available in such market other than only through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

SECTION 11. AMENDMENT. Section 26.1-36.3-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-06. Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers ~~at least two health benefit plans. Each small employer carrier shall offer one~~ all health benefit plans it actively markets to small employers in this state, including a basic health benefit plan and ~~one~~ a standard health benefit plan.

   b. (1) ~~A~~ Subject to subdivision a of subsection 1, a small employer carrier shall issue ~~a basic~~ any health benefit plan ~~or a standard health benefit plan~~ to any eligible small employer that applies for ~~either~~ the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter and section 26.1-36-37.2. However, a carrier may not be required to issue a health

benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 26.1-36.3-03, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans it actively markets to small employers, including at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a ~~basic or standard~~ health benefit plan, are not related to ~~the health status or claim experience~~ a health status-related factor of the small employer, and are applied consistently to all small employers applying for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

~~c. A small employer is eligible under subdivision b if it employed at least three or more eligible employees within this state on at least fifty percent of its working days during the preceding calendar quarter.~~

~~d. This subsection takes effect one hundred eighty days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to section 26.1-36.3-08; however, if the small employer health reinsurance program created pursuant to section 26.1-36.3-07 is not yet operative on that date, this section becomes effective on the date the program begins operation.~~

2. a. A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed under this subdivision may be used by a small employer carrier beginning sixty days after it is filed unless the commissioner disapproves its use.

b. The commissioner after providing notice and an opportunity for a hearing to the small employer carrier, may disapprove, at any time, the continued use by a small employer carrier of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter and section 26.1-36-37.2.

3. Health benefit plans covering small employers must comply with the following:

a. A health benefit plan may ~~not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a~~

~~preexisting condition.~~ ~~A health benefit plan may not define a preexisting condition more restrictively than~~ impose a preexisting condition exclusion only if:

(1) ~~A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or~~ The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;

(2) ~~A pregnancy existing on~~ The exclusion extends for a period of not more than twelve months after the effective date of coverage~~.~~;

(3) The exclusion does not relate to pregnancy as a preexisting condition; and

(4) The exclusion does not treat genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

b. A small employer carrier shall ~~waive~~ reduce any time period applicable to a preexisting condition exclusion or limitation period ~~with respect to particular services for the period of time an individual was previously covered~~ by the aggregate of periods the individual was covered by qualifying previous coverage ~~that provided benefits with respect to the services~~, if any, if the qualifying previous coverage was continuous until at least ~~ninety~~ sixty-three days prior to the effective date of the new coverage. ~~The period of continuous coverage may not include a waiting period for the effective date of the new coverage applied by the employer or the carrier~~ Any waiting period applicable to an individual for coverage under a group health benefit plan may not be taken into account in determining the period of continuous coverage. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan. Small employer carriers shall credit coverage by either a standard method or an alternative method. The commissioner shall adopt rules for crediting coverage under the standard and alternative method. These rules must be consistent with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any federal rules adopted pursuant thereto.

c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

d. (1) Except as provided in this subdivision, a small employer carrier shall apply requirements used to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees who are applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (a) Except as provided in subparagraph b, a small employer carrier, in applying minimum participation requirements with respect to a small employer, shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.

(4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

4. a. A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications under subsection 1 to a small employer if:

(1) ~~A~~ The small employer ~~who applies for coverage is not physically located in the carrier's established geographic~~

~~service area~~ does not have eligible individuals who live, work, or reside in the service area for such network plan; or

(2) ~~An employee who applies for coverage does not work or reside within the carrier's established geographic service area; or~~ The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier has demonstrated, if required, to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contractholders and enrollees, and that it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

~~(3) Within an area the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that, because of its obligations to existing group policyholders and enrollees, it will not have the capacity within its established geographic service area to deliver service adequately to the members of the groups.~~

b. ~~A small employer carrier that cannot offer coverage pursuant to paragraph 3 of subdivision a may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees or to any small employer groups until the later of one hundred eighty days following each refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.~~ A small employer carrier, upon denying health insurance coverage in any service area in accordance with paragraph 2 of subdivision a, may not offer coverage in the small employer market within the service area for a period of one hundred eighty days after the date the coverage is denied.

5. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that ~~requiring the acceptance of small employers in accordance with the provisions of subsection 1 would place the small employer carrier in a financially impaired condition~~ the carrier does not have the financial reserves to underwrite additional coverage and is applying this section uniformly without regard to the claims experience of small employers or any health status-related factor relating to employees and their dependents. A small employer carrier denying coverage in accordance with this section may not offer coverage in connection with a group health benefit plan in the small group market for a period of one hundred eighty days after the health coverage is denied or until the carrier has demonstrated to the commissioner sufficient financial reserves to underwrite financial coverage, whichever is later.

6. This section does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

SECTION 12. AMENDMENT. Subsection 1 of section 26.1-36.3-11 of the North Dakota Century Code is amended and reenacted as follows:

1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. ~~If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.~~

SECTION 13. AMENDMENT. Section 26.1-36.4-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-02. Definitions. As used in this chapter, the definitions in section 26.1-36.3-01 apply, unless the context otherwise requires. In addition:

1. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization that provides a plan of health insurance or health benefits subject to state insurance regulation.

2. "Policy" means any ~~hospital or medical or major medical policy, certificate, or subscriber contract issued on a group or individual basis by an insurer. The term does not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, or automobile medical payment insurance, or a policy or certificate of specified disease, hospital confinement indemnity, limited benefit health insurance, or short-term major medical policies with policy terms no longer than twelve months~~ health benefit plan as defined in section 26.1-36.3-01, whether offered on a group or individual basis. The term does not include short-term major medical policies offered in the individual market.

3. "Short-term", except as required by the Health Insurance Portability and Accountability Act of 1996, means a policy or plan providing coverage for one hundred eighty-five days or less.

SECTION 14. AMENDMENT. Section 26.1-36.4-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-03. Limits on preexisting ~~conditions provisions~~ condition exclusions. ~~A policy must provide coverage, with respect to a disease or physical condition of a person which existed prior to the effective date of the person's coverage under the policy, except for a preexisting disease or physical condition that was diagnosed or treated within the six months immediately prior to the effective date of the person's coverage. The limitation may not apply to loss incurred after the end of the twelve-month period commencing on the effective date of the person's coverage.~~ An insurer may impose a preexisting condition exclusion only if:

1. The exclusion relates to a condition, regardless of the cause of the condition, for which medical diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of the person's coverage.

2. The exclusion extends for a period of not more than twelve months after the effective date of coverage.

SECTION 15. Section 26.1-36.4-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-36.4-03.1. Additional limits on preexisting condition exclusions. A group policy may not impose a preexisting condition exclusion that:

1. Relates to pregnancy as a preexisting condition.

2. Treats genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

SECTION 16. AMENDMENT. Section 26.1-36.4-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-04. Portability of insurance policies. An insurer shall ~~waive~~ reduce any time period applicable to a preexisting condition, for a policy ~~with respect to particular services for the period of time an individual was previously covered~~ by the aggregate of periods the individual was covered by qualifying previous coverage ~~that provided benefits with respect to the services~~, if the qualifying previous coverage as defined in section 26.1-36.3-01 is continuous until at least ~~ninety~~ sixty-three days before the effective date of the new coverage. ~~The period of continuous coverage may not include a waiting period or the effective date of the new coverage applied by the insurer.~~ Any waiting period applicable to an individual for coverage under a health benefit plan may not be taken into account in determining the period of continuous coverage. Insurers shall credit coverage in the same manner as provided by section 26.1-36.3-06 and the rules adopted by the commissioner pursuant thereto.

SECTION 17. AMENDMENT. Section 26.1-36.4-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-05. Guaranteed renewability of health insurance coverage - Discrimination prohibited.

~~1. An insurer issuing policies under this chapter shall provide for the renewability or continuability of coverage unless:~~

~~a. The individual or group has failed to pay the required premiums.~~

~~b. The individual or group has misrepresented information or committed fraud with respect to coverage of the individual or group.~~

~~c. The group has failed to comply with the insurer's minimum participation requirements.~~

~~d. The insurer has elected to nonrenew all of its policies, other than guaranteed renewable individual policies, in this state. In that case the insurer shall:~~

~~(1) Provide advance notice of its decision not to renew to the commissioner; and~~

~~(2) Provide notice of the decision not to renew coverage to every affected insured and to the commissioner at least one hundred eighty days before the nonrenewal of the policy or contract by the insurer. Notice to the commissioner under this paragraph must be provided at least three business days before notice to an affected insured.~~

~~2. An insurer that elects not to renew a policy as required by this section may not write new business in the individual or group market in this state for a period of five years from the date of notice of its intention not to renew.~~

~~3. The commissioner may allow an insurer to nonrenew a policy if the commissioner finds that continuation of coverage is not in the best interests of policyholders or it would impair the insurer's ability to meet its contractual obligations. The commissioner shall assist the policyholder in finding replacement coverage.~~

1. An insurer issuing policies or certificates under this chapter shall provide for the renewability or continuability of coverage unless:

a. The individual or group has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the insurer has not received timely premium payments.

b. The individual or group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the insurer's minimum group participation requirements.

d. Noncompliance with the insurer's employer group contribution requirements.

e. A decision by the insurer to discontinue offering a particular type of health insurance coverage in the group or individual market. A type of group health benefit plan or individual policy may be discontinued by the insurer in that market only if the insurer:

(1) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage to all affected individuals, employers, participants, beneficiaries, and to the commissioner in each state in which an affected insured is known to reside at least ninety days prior to the nonrenewal of any health benefit plans by the insurer. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected individuals, employers, participants, and beneficiaries;

(3) Offers to each affected group or individual the option to purchase all other health benefit plans or individual coverage currently being offered by the insurer in that market; and

(4) In exercising the option to discontinue the particular type of group health benefit plan or individual coverage and in offering the option of coverage under paragraph 3, the insurer acts uniformly without regard to claims experience or any health status-related factor relating to any affected individuals, participants, or beneficiaries covered or new individuals, participants, or beneficiaries who may become eligible for such coverage.

f. A decision by the insurer to discontinue offering and to nonrenew all its health benefit plans or individual coverage delivered or issued for delivery to employers or individuals in this state. In such a case, the insurer shall:

(1) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage to all affected individuals, employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the insurer. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected individuals, employers, participants, and beneficiaries; and

(3) Discontinue all health insurance issued or delivered for issuance in the state's group or individual market and not renew such health coverage in that market.

g. In the case of health benefit plans that are made available in the group or individual market only through one or more associations, the membership of an employer or individual in the association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the insurer's ability to meet its contractual obligations. In this case the commissioner shall assist affected insureds in finding replacement coverage.

2. An insurer that elects not to renew a health benefit plan under subdivision f of subsection 1 may not write new business in the applicable market in this state for a period of five years from the date of notice to the commissioner.

3. In the case of an insurer doing business in one established geographic service area of the state, this section only applies to the insurer's operations in that service area.

4. An insurer offering coverage through a network plan may not be required to offer coverage or accept applications pursuant to subsection 1 or 2 in the case of the following:

   a. To an eligible person who no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor; or

   b. To an insurer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the insurer, or the area for which the insurer is authorized to do business.

5. At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered to a group or individual, if the modification is consistent with state law and effective on a uniform basis.

SECTION 18. REPEAL. Section 26.1-08-05 of the North Dakota Century Code is repealed.

SECTION 19. APPLICATION. Except as required by the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.], this Act applies to:

1. Any health insurance coverage that is offered, sold, issued, or renewed in the individual market after June 30, 1997; and

2. Any group health benefit plan, and health insurance coverage offered in connection with a group health benefit plan, for any plan year beginning after June 30, 1997.

SECTION 20. EFFECTIVE DATE. This Act becomes effective on July 1, 1997.

SECTION 21. EMERGENCY. This Act is declared to be an emergency measure.

Approved April 11, 1997
Filed April 11, 1997

CHAPTER 252

HOUSE BILL NO. 1259

(Representative Berg)
(Senator Mutch)

MUTUAL INSURANCE COMPANY REORGANIZATION

AN ACT to create and enact chapter 26.1-12.1 of the North Dakota Century Code, relating to the reorganization of mutual insurance companies and formation by mutual insurance companies of mutual insurance holding companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-12.1 of the North Dakota Century Code is created and enacted as follows:

26.1-12.1-01. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Commissioner" means the commissioner of insurance.

2. "Eligible member" means a policyholder whose policy is in force as of the record date or member as defined under the bylaws or articles of incorporation of the reorganizing insurer. Unless otherwise provided in the reorganization plan, a person insured under a certificate issued under a group policy is not an eligible member.

3. "Membership interest" means all eligible members of the reorganizing insurer, including rights to vote and to participate in any distribution of surplus, whether or not incident to the company's liquidation.

4. "Mutual insurance company" means a mutual insurance company incorporated under the laws of this state pursuant to chapter 26.1-12 or other prior provisions of this title.

5. "Mutual insurance holding company" means a company formed under section 26.1-12.1-02.

6. "Plan of reorganization" means a plan to engage or participate in a reorganization subject to this chapter.

7. "Policy" means a policy or contract of insurance issued by a mutual insurance company, including an annuity contract.

8. "Record date" means the date the reorganizing insurer's board of directors adopts a plan of reorganization or some other date specified as the record date in the plan of reorganization and approved by the commissioner.

9. "Reorganization" means any plan or transaction described in section 26.1-12.1-02 or 26.1-12.1-03, or any change in the reorganized insurer's articles of incorporation or bylaws which is a material change to the plan of reorganization filed and approved by the commissioner affecting

the ability of the reorganizing insurer to meet the standards described in section 26.1-12.1-06.

10. "Reorganized insurance company" means a mutual insurance company that has completed a reorganization to a stock company that is subject to this chapter.

11. "Reorganizing insurer" means a mutual insurance company seeking to participate, or participating, in merger or other reorganization as defined in this chapter.

26.1-12.1-02. Mutual insurance holding company - Formation. A domestic mutual insurance company, upon approval of the commissioner, may reorganize by forming an insurance holding company based upon a mutual plan and continuing the corporate existence of the reorganizing insurer as a stock insurance company. The commissioner, if satisfied the reorganization meets the standards set forth in section 26.1-12.1-06, may approve the proposed plan of reorganization or may require as a condition of approval the modification of the proposed plan of reorganization as the commissioner finds necessary for the plan to meet the standards of section 26.1-12.1-06. The commissioner shall retain jurisdiction over the mutual insurance holding company and the reorganized insurer according to this section and chapter 26.1-10 to assure that policyholders' and members' interests are protected.

All of the initial shares of the capital stock of the reorganized insurer must be issued to the mutual insurance holding company or to an intermediate stock holding company that is wholly owned by the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurer must be converted into membership interests in the mutual insurance holding company. Policyholders of the reorganizing insurance company must become members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company and the articles of incorporation and bylaws of the reorganized insurance company as approved by the commissioner. The mutual insurance holding company, directly or indirectly through an intermediate stock holding company, must control at all times a majority of the voting shares of the capital stock of the reorganized insurance company but this does not prohibit any future demutualization or other conversion.

26.1-12.1-03. Mutual insurance holding company - Merger. A domestic mutual insurance company, upon the approval of the commissioner, may reorganize by merging its policyholders' member interests into a mutual insurance holding company formed according to section 26.1-12.1-02 and continuing the corporate existence of the reorganizing insurer as a stock insurance company subsidiary of the mutual insurance holding company. The commissioner, if satisfied that the reorganization meets the standards in section 26.1-12.1-06, may approve the proposed merger or may require as a condition of approval the modification of the proposed merger as the commissioner finds necessary for the merger to meet the standards in section 26.1-12.1-06. The commissioner shall retain jurisdiction over the mutual insurance holding company and the reorganized insurer organized according to this section to assure that the policyholders' and members' interests are protected.

All of the initial shares of the capital stock of the reorganized insurance company must be issued to the mutual insurance holding company, or to an intermediate stock holding company that is wholly owned by the mutual insurance holding company. The membership interests of the policyholders of the reorganizing

insurer must be converted into membership interests in the mutual insurance holding company. Policyholders of the reorganized insurance company must become members of the mutual insurance holding company according to the articles of incorporation and bylaws of the mutual insurance holding company. A merger as contemplated by this section is not subject to chapter 26.1-07.

26.1-12.1-04. Plan of reorganization - Contents. No insurer authorized to do business in this state may take part in a reorganization unless the reorganization has first been approved by the commissioner in accordance with this chapter. A reorganizing insurer shall file a plan of reorganization consistent with the requirements of this section, approved by the affirmative vote of a majority of its board of directors, for review and approval by the commissioner. The plan must include:

1. A description of the nature and content, or a copy, of the annual report and financial statement to be sent to each eligible member.

2. An analysis of the benefits and risks attendant to the proposed reorganization, including the rationale for the reorganization and analysis of the comparative benefits and risks to the reorganizing insurer of the reorganization.

3. Information sufficient to demonstrate the financial condition of the reorganizing insurer will not be affected adversely upon reorganization.

4. Information demonstrating that the reorganization will:

   a. Establish a mutual insurance holding company with at least one stock insurance company subsidiary, the majority of whose shares must be owned, either directly or through an intermediate stock holding company, by the mutual insurance holding company;

   b. Ensure immediate membership in the mutual insurance holding company of all existing eligible members of the reorganizing mutual insurance company;

   c. Describe a plan providing for membership interest of future policyholders;

   d. Include a copy of the proposed mutual insurance holding company's articles of incorporation and bylaws specifying all membership rights;

   e. Include a copy of the articles of incorporation and bylaws of the reorganizing insurer, any proposed insurance company subsidiary, or intermediate holding company subsidiary; and

   f. Describe the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

5. Information demonstrating that upon an insolvency involving a stock insurance company subsidiary of the mutual insurance holding company that resulted from the reorganization, the assets of the mutual holding company will be available to satisfy the policyholder obligations of the stock insurance company.

6. Information describing the mutual insurance holding company's general plans regarding whether any accumulation or prospective accumulation of earnings by the mutual insurance holding company which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary will inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

26.1-12.1-05. Retention of experts. The commissioner may retain, at the reorganizing insurer's reasonable expense, any qualified experts if the commissioner determines that staff not otherwise a part of the commissioner's staff is necessary to assist in reviewing the plan.

26.1-12.1-06. Hearing by commissioner - General duties. The commissioner shall conduct a public hearing regarding a proposed reorganization plan within sixty days after submission of a completed plan of reorganization to the commissioner, unless the commissioner and reorganizing insurer agree to extend the sixty days or unless the commissioner and the reorganizing insurer, based upon the facts and circumstances of the transaction, agree that a hearing may be waived. If a hearing is held, the commissioner shall give the reorganizing insurer at least twenty days' notice of the hearing. At the hearing, the reorganizing insurer, its policyholders, and any other person whose interests may be affected by the proposed reorganization, may present evidence, examine and cross-examine witnesses, and offer oral and written arguments and comments according to the procedure for contested cases under chapter 28-32. The commissioner, in making the determination as to a plan of reorganization under this chapter, shall consider whether:

1. The reorganizing insurer's surplus in regard to policyholders following a plan of reorganization is reasonable in relation to the reorganizing insurer's outstanding liabilities and adequate to its financial needs;

2. Under a plan of reorganization that materially affects the membership interest of eligible members in the reorganizing insurer, the eligible members will receive a membership interest in a mutual holding company commensurate with an equitable share of the value of the reorganizing insurer;

3. After the reorganization, the reorganized insurance company will be able to satisfy the requirements for the issuance of a certificate of authority to write the lines of insurance for which it was licensed before the reorganization; and

4. The plan of the reorganization is fair, reasonable, and equitable to the policyholders of the reorganizing insurer.

26.1-12.1-07. Action by commissioner. Within sixty days after the conclusion of the public hearing, or within the sixty days after filing the plan of reorganization if by mutual agreement the hearing is waived, unless there is a mutual agreement by the commissioner and the reorganizing insurer to extend such time, the commissioner shall enter findings of fact, conclusions of law, and an order either approving, conditionally approving, or disapproving the plan. An approval or conditional approval of a plan of reorganization expires if the reorganization is not completed within one hundred eighty days after the approval or conditional approval, unless the time period is extended by the commissioner upon a showing of good cause.

26.1-12.1-08. Notice to eligible members. Following approval or conditional approval of the plan by the commissioner, all eligible members shall be given notice of a regular or special meeting of the policyholders called for the purpose of considering the plan and any corporate action that is a part of, or is reasonably attendant to, the accomplishment of the plan. A copy of the plan or a summary of the plan must accompany the notice. A notice approved by the commissioner must be mailed to each eligible member's last known address, as shown on the reorganizing insurer's records, within forty-five days of the commissioner's approval of the plan, unless the commissioner directs an earlier date for mailing. The meeting to vote upon a plan of reorganization must be set for a date no less than forty-five days after the date when the notice of the meeting is mailed by the reorganizing insurer, unless the commissioner directs an earlier date for the meeting. If the meeting to vote upon the plan of reorganization is held coincident with the reorganizing insurer's annual meeting of policyholders or members, only one combined notice of meeting is required. If the reorganizing insurer complies substantially and in good faith with the notice requirements of this section, the reorganizing insurer's failure to give any member or members any required notice does not impair the validity of any action taken under this section.

26.1-12.1-09. Approval by eligible members. The plan of reorganization must be adopted upon receiving the affirmative vote of a majority of the votes cast by eligible members. Eligible members may vote in person or by proxy. The form of any proxy along with a copy or summary of the plan which accompanied the notice to eligible members must be filed with and approved by the commissioner. The number of votes each eligible member may cast must be determined by the converting reorganizing insurer's bylaws. If the bylaws are silent, each eligible member may cast one vote. The plan must be approved as follows:

1. In the case of formation of a mutual insurance holding company under section 26.1-12.1-02, the reorganization plan must be approved by the affirmative vote of a majority of the votes cast by no less than ten percent of the eligible members of the reorganizing insurer; and

2. In the case of a merger under section 26.1-12.1-03, the reorganization plan must be approved by an affirmative vote of a majority of the votes cast by no less than ten percent of the eligible members of the reorganizing insurer and by an affirmative vote of a majority of the votes cast by no less than ten percent of the eligible members of the mutual insurance holding company into which the policyholders' membership interests are to be merged, provided that the vote of the eligible members of the mutual insurance holding company may not be required if the commissioner determines that the merger would not be material to the financial condition of the mutual insurance holding company.

26.1-12.1-10. Applicability of certain provisions. A mutual insurance holding company is deemed to be an insurer subject to chapter 26.1-06.1 and is automatically a mandatory party to any proceeding under that chapter involving an insurance company that, as a result of a reorganization according to section 26.1-12.1-02 or section 26.1-12.1-03, is a subsidiary of the mutual insurance holding company. In any proceeding under chapter 26.1-06.1 involving the reorganized insurance company, the assets of the mutual insurance holding company are considered to be the assets of the estate of the reorganized insurance company for purposes of satisfying the claims of the reorganized insurance company's policyholders. A mutual insurance holding company may not dissolve or liquidate without the approval of the commissioner or as ordered by the district court

according to chapter 26.1-06.1. Section 26.1-12-32 is not applicable to a reorganization or merger accomplished under this chapter.

26.1-12.1-11. Membership interest. A membership interest in a domestic mutual insurance holding company does not constitute a security as defined in subsection 13 of section 10-04-02. No member of a mutual insurance holding company may transfer or pledge membership in the mutual insurance holding company or any right arising from the membership except as attendant to the valid transfer or assignment of the member's policy in any reorganized insurer which gave rise to the member's membership interest. A member of a mutual insurance holding company is not, as a member, personally liable for the acts, debts, liabilities, or obligations of the reorganized insurer. No assessment of any kind may be imposed upon the members of a mutual insurance holding company by the directors or members, or because of any liability of any company owned or controlled by the mutual insurance holding company, or because of any act, debt, or liability of the reorganized company. A member's interest in the mutual insurance holding company automatically terminates upon cancellation, nonrenewal, expiration, or termination of the member's policy in any reorganized company which gave rise to the member's membership interest.

26.1-12.1-12. Sale of stock and payment of dividends. No solicitation for the sale of any of the stock of the reorganized insurer, or of an intermediate stock holding company of the mutual insurance holding company, may be made without the commissioner's prior written approval. Dividends and other distributions to the shareholders or members of the reorganized mutual insurance company or of an intermediate stock holding company may not be made except in compliance with sections 26.1-10-05 and 26.1-10-05.1.

26.1-12.1-13. Incorporation. A mutual insurance holding company resulting from the reorganization of a domestic mutual insurance company must be incorporated under chapter 10-19.1. The articles of incorporation of the mutual insurance holding company are subject to approval of the commissioner in the same manner as those of an insurance company.

26.1-12.1-14. Applicability. This chapter does not apply to any mutual insurance company that was formerly organized as a nonprofit health service corporation.

Approved April 3, 1997
Filed April 3, 1997

CHAPTER 253

SENATE BILL NO. 2270

(Senators Lips, DeMers)
(Representatives Kilzer, Wald)

NONPROFIT HEALTH SERVICE CORPORATION CONVERSION

AN ACT to create and enact a new subsection to section 26.1-17-33.1 of the North Dakota Century Code, relating to nonprofit mutual insurance companies; to amend and reenact section 26.1-17-33.1 of the North Dakota Century Code, relating to the conversion of a nonprofit health service corporation to a nonprofit mutual insurance company; to provide for retroactive application; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-33.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-33.1. Nonprofit health service corporation - Conversion to nonprofit mutual insurance company - Application of law.

1. Any nonprofit health service corporation organized under chapter 26.1-17, having admitted assets in excess of all liabilities at least equal to the original surplus required of a mutual insurance company by section 26.1-12-10, without reincorporation, and upon adoption of a resolution by its board of directors, may petition the commissioner of insurance for an order to become a nonprofit mutual insurance company subject to chapter 26.1-12. For the purpose of obtaining approval from the commissioner of insurance, conversion to a nonprofit mutual insurance company under this section is deemed a consolidation pursuant to chapter 26.1-07 and the procedure described therein must be followed.

2. Upon becoming subject to chapter 26.1-12, the company may continue to provide health care and related services to its present or future members and subscribers by health care contracts and may make provision for the payment of health care services directly to hospitals and other agencies or institutions or persons rendering health care services or related services or may make direct payment to the member or subscriber. The conversion of a nonprofit health service corporation into a mutual insurance company must not impair the rights or obligations or any existing contractual rights of a health care service corporation or its members. Except as provided in this section, the laws that apply to mutual insurance companies, and insurance companies generally, apply to a nonprofit mutual insurance company converted from a nonprofit health service corporation pursuant to this section.

3. The nonprofit corporation laws apply to the operation and control of a nonprofit mutual insurance company converted from a nonprofit health service corporation under this section and supersede any conflicting provisions in title 26.1 unless title 26.1 is more restrictive. Except as

authorized in subsections 4 and 5, a nonprofit mutual insurance company may not sell, lease, transfer, or dispose of all or substantially all property or assets, and may not merge or consolidate with, or acquire, a stock insurance company or agency, for-profit subsidiary, or any other corporation. Except as provided in subsection 5, a nonprofit mutual insurance company may not pay dividends or issue stock.

4. The funds of a nonprofit mutual insurance company may be invested in those investments authorized to be made by domestic insurance companies under section 26.1-05-19, as limited by section 26.1-05-18.

5. A nonprofit mutual insurance company may form a stock insurance company for the purpose of administering medicare claims.

6. A nonprofit mutual insurance company may not demutualize or be converted to a for-profit mutual or stock company.

7. A nonprofit mutual insurance company may not avail itself of the additional investment authority under chapter 26.1-10.

8. A conversion of a nonprofit health service corporation to a nonprofit mutual insurance company under this section, to the extent that any assets of the nonprofit health service corporation are impressed with a charitable trust immediately before the conversion, does not give rise to a breach of the charitable trust or violate any fiduciary duty laws, and does not constitute grounds for disapproval of either the petition to convert to a nonprofit mutual insurance company or the articles of incorporation of the company under section 26.1-12-04. The conversion authorized by this section does not diminish the application of charitable trust or fiduciary duty laws that may apply to the company immediately before the conversion.

9. A nonprofit mutual insurance company may not engage in the practice of medicine, dentistry, optometry, or any other profession for which a license or registration is required.

10. Every nonprofit mutual insurance company is a charitable and benevolent organization and the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit mutual insurance companies.

SECTION 2. A new subsection to section 26.1-17-33.1 of the North Dakota Century Code is created and enacted as follows:

A nonprofit mutual insurance company may not form a mutual insurance holding company.

SECTION 3. RETROACTIVE APPLICATION OF ACT. This Act applies retroactively to any conversion from a nonprofit health service corporation to a nonprofit mutual insurance company or a petition to convert or procedure for conversion from a nonprofit health service corporation to a nonprofit mutual insurance company under section 26.1-17-33.1 which occurs before the effective date of this Act.

SECTION 4. EFFECTIVE DATE. Section 2 of this Act becomes effective when 1997 House Bill No. 1259 becomes effective.

Approved April 2, 1997
Filed April 3, 1997

CHAPTER 254

HOUSE BILL NO. 1428

(Representatives Henegar, Kilzer)

OFF-LABEL DRUG USE COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to coverage for off-label uses of drugs.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Coverage for off-label uses of drugs.

1. In this section:

   a. "Coverage of a drug" includes medically necessary services associated with the administration of the drug.

   b. "Medical literature" means scientific studies published in a peer review national medical journal.

   c. "Off-label use of drugs" means prescribing drugs for treatments other than those stated in the labeling approved by the federal food and drug administration.

   d. "Standard reference compendia" means the United States pharmacopeia drug information or American hospital formulary service drug information.

2. An insurance company, nonprofit health service corporation, or health maintenance organization that provides coverage for drugs may not issue, deliver, execute, or renew any health insurance policy or health service contract on an individual, group, blanket, franchise, or association basis which excludes coverage of a drug for a particular indication on the grounds the drug has not been approved by the federal food and drug administration for that indication if the drug is recognized for treatment of the indication in one of the standard reference compendia or medical literature.

3. The commissioner of insurance may direct an insurer or contractor regulated by this section to make payments as required by this section.

4. The state health officer may appoint a panel of up to eight qualified medical experts to review off-label uses of drugs not included in the standard reference compendia or medical literature. This panel shall advise the commissioner of insurance whether a particular off-label use is medically appropriate and shall make recommendations regarding payment of off-label use.

5. This section does not alter existing law regarding provisions limiting the coverage of drugs that have not been approved by the federal food and drug administration; does not require coverage for any drug when the federal food and drug administration has determined its use to be contraindicated; and does not require coverage for experimental drugs not otherwise approved for any indication by the federal food and drug administration.

Approved March 25, 1997
Filed March 25, 1997

CHAPTER 255

SENATE BILL NO. 2040

(Legislative Council)
(Insurance and Health Care Committee)
(Senators Mathern, Thane, Lee)
(Representatives Glassheim, Mahoney)

MENTAL DISORDER COVERAGE

AN ACT to amend and reenact section 26.1-36-09 of the North Dakota Century Code, relating to group health policy and health service contract mental disorder coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[2] **SECTION 1. AMENDMENT.** Section 26.1-36-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09. Group health policy and health service contract mental disorder coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental disorder and other related illness, which benefits meet or exceed the benefits provided in subsection 2.

2. a. The benefits must be provided for inpatient treatment ~~and~~, treatment by partial hospitalization, residential treatment, and outpatient treatment.

   b. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of sixty days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined in subsection 25 of section 52-01-01 and rules of the state department of health pursuant thereto offering treatment for the prevention or cure of mental disorder or other related illness.

   c. In the case of benefits provided for partial hospitalization or residential treatment, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a

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[2] Section 26.1-36-09 was also amended by section 1 of House Bill No. 1161, chapter 379.

hospital as defined in subsection 25 of section 52-01-01 and rules of the state department of health pursuant thereto or by a regional human service center licensed under section 50-06-05.2, offering treatment for the prevention or cure of mental disorder or other related illness, or by a residential treatment program. For services provided in regional human service centers, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

d. Benefits ~~may also~~ must be provided for a combination of inpatient ~~and~~ hospitalization, partial hospitalization, and residential treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization or residential treatment; provided, however, that no more than forty-six days of the inpatient treatment benefits required by this section may be traded for treatment by partial hospitalization or residential treatment.

e. (1) In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of thirty hours for services covered under this section in any calendar year if the treatment services are provided within the scope of licensure by a nurse who holds advanced licensure with a scope of practice within mental health or if the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, or a licensed certified social worker who:

(a) Possesses a master's or doctorate degree in social work from an institution accredited by the council of social work education;

(b) Has at least one year of direct clinical social work practice during graduate school or one year of postgraduate supervised clinical social work practice in a structured teaching environment;

(c) Has completed at least the equivalent of four years of full-time supervised clinical social work experience within the last seven years;

(d) Has passed the clinical examination or its equivalent offered by the North Dakota board of social work examiners; and

(e) If not licensed in this state, is licensed, certified, or registered at the highest level of social work practice in another state.

(2) A person who is qualified for third-party payment by the board of social work examiners on August 1, 1995, is exempt from subparagraphs c and d. Supervision under subparagraph c may be provided by a qualified clinical social

worker, a licensed psychologist, or a licensed psychiatrist, but the preferred supervisor is the qualified clinical social worker.

(3) Upon the request of an insurance company, a nonprofit health service corporation, or a health maintenance organization the North Dakota board of social work examiners shall provide to the requesting entity information to certify that a licensed certified social worker meets the qualifications required under this section.

(4) The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five hours in any calendar year, and may not establish a copayment greater than twenty percent for the remaining hours.

(5) If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those hours after the first five hours in any calendar year.

f. "Partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

g. "Residential treatment" has the same meaning as provided in section 25-03.2-01.

3. This section does not prevent any insurance company, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, where the policy or contract is not subject to such provisions.

Approved March 25, 1997
Filed March 26, 1997

CHAPTER 256

SENATE BILL NO. 2115

(Senator Nalewaja)
(Representative Hausauer)

PROSTATE-SPECIFIC ANTIGEN TEST COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to insurance coverage for prostate-specific antigen tests.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance policy and health service contract - Prostate-specific antigen test coverage. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides an annual digital rectal examination and a prostate-specific antigen test for an asymptomatic male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.

Approved April 2, 1997
Filed April 3, 1997

CHAPTER 257

SENATE BILL NO. 2194

(Senators W. Stenehjem, Holmberg, Lee)
(Representatives Delmore, Kliniske, Poolman)

INHERITED METABOLIC DISEASE COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to health insurance coverage for inherited metabolic disease; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Foods and food products for inherited metabolic diseases.

1. As used in this section:

   a. "Inherited metabolic disease" means maple syrup urine disease or phenylketonuria.

   b. "Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.

   c. "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a physician.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prescription coverage on an individual, group, blanket, franchise, or association basis, unless the policy or contract provides, for any person covered under the policy or contract, coverage for medical foods and low protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease.

3. This section applies to any covered individual born after December 31, 1962. This section does not require coverage for low protein modified food products in excess of three thousand dollars per year for an individual with an inherited metabolic disease of amino acid or organic acid.

SECTION 2. EXPIRATION DATE. This Act is effective through July 31, 1999, and after that date is ineffective.

Approved April 11, 1997
Filed April 11, 1997

CHAPTER 258

SENATE BILL NO. 2043

(Legislative Council)
(Insurance and Health Care Committee)
(Senators Mathern, DeMers, Thane)
(Representatives Glassheim, Wald, R. Kelsch)

MOTHER AND NEWBORN POSTDELIVERY COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to health insurance coverage for mothers and newborns.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance policy and health service contract - Postdelivery coverage for mothers and newborns.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides maternity benefits on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

   a. Inpatient care for at least forty-eight hours for a mother and her newborn child following a normal vaginal delivery, and inpatient care for at least ninety-six hours following a caesarean section, without requiring the attending physician or health care provider to obtain authorization to care for a mother and her newborn child in the inpatient setting for this period of time.

   b. Inpatient care in excess of forty-eight hours following a vaginal delivery and ninety-six hours following a caesarean section if the stay is determined to be reasonable and medically necessary.

2. Coverage is not required for postdelivery inpatient care for a covered mother and her newborn child during the entire minimum time period required under subdivision a of subsection 1 if:

   a. The attending physician or health care provider, in consultation with the mother, decides to discharge the mother and her newborn child early; and

   b. The mother and her newborn child meet the minimum medical criteria for discharge as recommended in the "Guidelines for

Perinatal Care" prepared by the American college of obstetricians and gynecologists and the American academy of pediatrics.

3. A person covered under this section is not required to give birth in a hospital or stay in a hospital for a fixed period of time following the birth of her child or participate in any postdelivery visit.

4. An insurance company, nonprofit health service corporation, health maintenance organization, or provider may not:

   a. Provide monetary payments or rebates to any insured person to request less than the minimum coverage required under this section;

   b. Penalize or otherwise reduce or limit the reimbursement of an attending physician or health care provider for recommending or providing care that is covered under this section;

   c. Waive any deductible, coinsurance, or copayment requirement for providing the minimum coverage required under this section;

   d. Deny to the mother or newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely to avoid the requirements of this section; or

   e. Provide incentives, monetary or otherwise, to an attending physician or health care provider to induce the physician or provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

5. The coverage required under subsection 1 may not exceed policy aggregate limits for this coverage.

6. This section does not prevent an insurance company, nonprofit health service corporation, or health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay relating to childbirth for a mother or newborn child under the plan.

SECTION 2. NOTIFICATION OF COVERAGE. Before February 1, 1998, every insurance company, nonprofit health service corporation, and health maintenance organization subject to this Act shall provide written notice of a material change in coverage under section 1 of this Act to every policyholder or certificate holder affected by the change.

Approved April 17, 1997
Filed April 17, 1997

CHAPTER 259

HOUSE BILL NO. 1249
(Representative Keiser)

STRUCTURE INSURANCE COVERAGE

AN ACT to create and enact a new subsection to section 26.1-39-05 of the North Dakota Century Code, relating to insurance coverage on structures.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-39-05 of the North Dakota Century Code is created and enacted as follows:

This section does not apply to any claim for loss of an appurtenant structure or separate structure. Any claim for loss of an appurtenant or separate structure must be settled for actual replacement cost or actual cash value, depending on the policy provisions applicable to the structure, unless an appurtenant or separate structure is individually described in the policy and a value is assigned to that specific structure before the loss.

Approved March 23, 1997
Filed March 24, 1997

CHAPTER 260

SENATE BILL NO. 2042

(Legislative Council)
(Insurance and Health Care Committee)
(Senators Mathern, Thane)
(Representatives Glassheim, Wald, Price, Svedjan)

QUALIFIED SERVICE PROVIDER QUALIFICATIONS

AN ACT to create and enact a new section to chapter 26.1-45 of the North Dakota Century Code, relating to qualifications of qualified service providers; to amend and reenact section 57-38-29.2 of the North Dakota Century Code, relating to an income tax credit for premiums paid for long-term care insurance coverage; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-45 of the North Dakota Century Code is created and enacted as follows:

Qualified service providers. Any insurance company providing long-term care coverage for home and community-based services shall pay a provider meeting qualified service provider standards a daily payment allowance as defined in the policy or certificate. "Qualified service provider" means a county agency or independent contractor that agrees to meet standards for personal attendant care service as established by the department of human services.

SECTION 2. AMENDMENT. Section 57-38-29.2 of the North Dakota Century Code is amended and reenacted as follows:

57-38-29.2. Credit for premiums for long-term care insurance coverage. A credit against an individual's tax liability under this chapter is ~~hereby~~ provided to each taxpayer in the amount of twenty-five percent of any premiums paid by the taxpayer for long-term care insurance coverage for the taxpayer or the taxpayer's spouse, parent, ~~or~~ stepparent, or child. The credit under this section for each ~~policy purchased under this chapter~~ insured individual may not exceed one hundred dollars in any taxable year.

SECTION 3. EFFECTIVE DATE. Section 2 of this Act is effective for taxable years beginning after December 31, 1996.

Approved April 8, 1997
Filed April 8, 1997

CHAPTER 261

SENATE BILL NO. 2396

(Senators Goetz, Grindberg, Wogsland)
(Representatives Dorso, Keiser, Poolman)

LOW-RISK INCENTIVE FUND ESTABLISHMENT

AN ACT to provide for establishment and operation of the North Dakota low-risk incentive fund; to provide a penalty; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in this Act:

1. "Fund" means the North Dakota low-risk incentive fund.

2. "Governing board" means the board of directors of the corporation or board of governors of the limited liability company established under section 2 of this Act.

3. "Insurer" means any foreign or domestic corporation, association, benefit society, exchange, partnership, limited liability company, or individual engaged as principal in the business of insurance in this state.

4. "Primary sector business" means an individual, corporation, limited liability company, partnership, or association that through the employment of knowledge or labor adds value to a product, process, or service which results in the creation of new wealth. Qualification as a primary sector business under this subsection must be determined by the department of economic development and finance.

SECTION 2. Establishment - Organization. Any insurer or group of insurers may establish a corporation or limited liability company to own and operate the North Dakota low-risk incentive fund. Except as provided in this Act, all authority regarding the articles of incorporation or articles of organization is the province of the governing board, which must include a representative of the Bank of North Dakota and the director of the department of economic development and finance. The Bank of North Dakota shall administer the fund; however, the governing board is responsible for adopting fund policies and procedures. The governing board may not distribute more than seventy-five percent of the net profit of the fund in any of the first five years of operation.

SECTION 3. North Dakota low-risk incentive fund use. The fund may be used only for making loans to low-risk businesses for primary sector business projects in this state and no loan may be approved or made by the fund without a ten percent participation in the aggregate amount of the loan by the Bank of North Dakota. The participation of the Bank of North Dakota in a loan may not exceed ten percent of the aggregate amount of the loan. A loan from the fund may not be made to an insurer. The governing board shall establish the rate of interest and terms of repayment for a loan from the fund. Fifty percent of the amount loaned from the fund during the first year of a biennium must be reserved solely for businesses in rural areas. The remainder loaned from the fund may be used in urban or rural areas. For purposes of this section, "rural areas" means the area of

the state not including territory within the corporate limits of a city with a population of twenty thousand or more.

SECTION 4. Loan administration. An application for a loan from the fund must contain the information prescribed by the governing board. Except as provided in this section, information contained in applications for loans from the fund is confidential. The Bank of North Dakota shall review each loan application, report to the governing board whether the applicant represents a primary sector business project, and make a recommendation to the governing board to either approve or disapprove the loan application. The Bank of North Dakota shall administer all loans issued by the fund and shall receive from the fund a service fee of twenty-five basis points on all loans in place. The commissioner of insurance may examine the fund and activities of insurers in connection with the fund to assure compliance with title 26.1. The fund shall pay for the costs of an examination and no credit may be allowed any insurer for payment of examination costs as otherwise provided under section 26.1-03-17.

SECTION 5. Audited financial statement - Report of fund operations. The governing board shall contract annually with a certified public accountant for performance of an audit and preparation of audited financial statements of the fund prepared in accordance with generally accepted accounting principles and a report containing an analysis of the impact of the fund on the state's economy, business and employment activity generated by loans from the fund, and the effects of that activity on state and local tax revenues. The governing board shall provide the financial statements and report to the governor, the commissioner of insurance, and the legislative council and make copies available to the public. The cost of the audit and preparation of financial statements and report must be paid from the fund.

SECTION 6. Tax credit - Penalty. If the requirements of this Act are met, an insurer is entitled to a credit against taxes due under section 26.1-03-17 as determined under this section.

1. An insurer making or participating in a loan under this Act is entitled to a premium tax credit calculated for each calender year the loan is in place. The amount of the credit is the difference between:

   a. The participating insurer's share of the interest earned on the loan during the calendar year; and

   b. The participating insurer's share of an amount of interest that would have been earned during the same period by applying an interest rate, calculated by adding three hundred basis points to a comparable treasury security rate at the date of the issuance of the loan.

2. The maximum credit allowed an insurer for any calendar year is the amount of interest that would have been earned during the period by applying an interest rate of three hundred basis points. A credit may not be allowed if the interest earned exceeds the interest that would have been earned by applying the calculation in subdivision b of subsection 1.

3. The credit may not exceed the total amount of the insurer's tax liability under subsection 1 of section 26.1-03-17 and no unused credit may be carried forward.

4. Credits under this section for all insurers may not exceed seven hundred fifty thousand dollars in a calendar year.

SECTION 7. Assets of insurers. The amount of a loan made by an insurer or the amount of an insurer's participation in a loan made under this Act may not be considered or reported on the insurer's annual statement as an admitted asset except to the extent provided under section 2 of Senate Bill No. 2132, as approved by the fifty-fifth legislative assembly.

SECTION 8. Assets of insurers. The aggregate amount of all loans made by an insurer under this Act or the aggregate amount of an insurer's participation in loans made under this Act may not at any time exceed five percent of the company's admitted assets or the amount equal to the company's capital and surplus in excess of the minimum capital and surplus required by law, whichever is less.

SECTION 9. EFFECTIVE DATE. Section 7 of this Act is effective July 1, 1997, if Senate Bill No. 2132 is approved by the fifty-fifth legislative assembly and becomes law, and is otherwise ineffective. Section 8 of this Act is effective July 1, 1997, if Senate Bill No. 2132 is not approved by the fifty-fifth legislative assembly or does not become law, and is otherwise ineffective.

Approved April 17, 1997
Filed April 17, 1997