

HOUSE BILL NO. 1137

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

1 A BILL for an Act to amend and reenact sections 26.1-08-06 and 26.1-08-06.1 of the North
2 Dakota Century Code, relating to minimum benefits and medicare supplement plans of a
3 qualified comprehensive health plan.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1. AMENDMENT.** Section 26.1-08-06 of the 1999 Supplement to the North
6 Dakota Century Code is amended and reenacted as follows:

7 **26.1-08-06. Minimum benefits of a qualified comprehensive plan.**

8 1. A plan of health coverage is a qualified comprehensive plan if it otherwise meets
9 the requirements established by ~~chapter~~ chapters 26.1-36; and 26.1-36.4 and the
10 other laws of the state, whether or not the policy is issued in this state, and meets
11 or exceeds the following minimum standards:

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

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

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

- 1 (3) Drugs requiring a physician's prescription.
- 2 (4) Services of a nursing home for not more than one hundred twenty days
- 3 in a year if the services commence within fourteen days following
- 4 confinement of at least three days in a hospital for the same condition.
- 5 (5) Service of a home health agency up to a maximum of two hundred
- 6 seventy visits per year.
- 7 (6) Use of radium or other radioactive materials.
- 8 (7) Oxygen.
- 9 (8) Anesthetics.
- 10 (9) Prostheses.
- 11 (10) Rental or purchase, as appropriate, of durable medical equipment.
- 12 (11) Diagnostic X-rays and laboratory tests.
- 13 (12) Oral surgery for partially or completely unerupted impacted teeth, a
- 14 tooth root without the extraction of the entire tooth, or the gums and
- 15 tissues of the mouth when not performed in connection with the
- 16 extraction or repair of teeth.
- 17 (13) Services of a physical therapist.
- 18 (14) Transportation provided by licensed ambulance service to the nearest
- 19 facility qualified to treat the condition.
- 20 (15) Substance abuse and mental disorders as outlined in sections
- 21 26.1-36-08 and 26.1-36-09.
- 22 c. Covered expenses must include, at the option of the eligible person, the usual
- 23 and customary charges for professional services rendered by a chiropractor
- 24 and for services and articles prescribed by a chiropractor for which an
- 25 additional premium may be charged.
- 26 d. Covered expenses for the services or articles specified in this subsection do
- 27 not include:
- 28 (1) Any charge for any care or for any injury or disease either arising out of
- 29 an injury in the course of employment and subject to a workers'
- 30 compensation or similar law, for which benefits are payable without
- 31 regard to fault under coverage statutorily required to be contained in

- 1 any motor vehicle or other liability insurance policy or equivalent
2 self-insurance, or for which benefits are payable under another accident
3 and health insurance policy or medicare.
- 4 (2) Any charge for treatment for cosmetic purposes other than surgery for
5 the repair of an injury or birth defect.
- 6 (3) Any charge for travel other than transportation provided by licensed
7 ambulance service to the nearest facility qualified to treat the condition.
- 8 (4) Any charge for confinement in a private room to the extent it is in
9 excess of the institution's charge for its most common semiprivate
10 room, unless the private room is prescribed as medically necessary by
11 a physician.
- 12 (5) That part of any charge for services or articles rendered or prescribed
13 by a physician, dentist, chiropractor, or other health care personnel
14 which exceeds the prevailing charge in the locality where the service is
15 provided.
- 16 (6) Any charge for services or articles the provision of which is not within
17 the scope of authorized practice of the institution or individual rendering
18 the services or articles.
- 19 (7) Care which is primarily for custodial or domiciliary purposes which
20 would not qualify as eligible services under medicare.
- 21 (8) Any charge for organ transplants unless prior approval is received from
22 the board of directors of the comprehensive health association.
- 23 2. A qualified comprehensive plan also must offer the eligible person the choice of an
24 annual deductible of not less than one thousand dollars per person instead of that
25 provided in subdivision a of subsection 1.

26 **SECTION 2. AMENDMENT.** Section 26.1-08-06.1 of the North Dakota Century Code
27 is amended and reenacted as follows:

28 **26.1-08-06.1. Qualified medicare supplement plan.** A qualified medicare supplement
29 plan ~~is a~~ includes medicare supplement ~~plan~~ plans A and F. This plan is These plans are
30 available to individuals who are eligible for medicare by reason of age or disability.