Fifty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2195

Introduced by

Senator J. Lee

Representative Price

A BILL for an Act to create and enact a new subsection to section 26.1-04-03 and four new sections to chapter 26.1-08 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota; to amend and reenact subsection 2 of section 26.1-03-17 and sections 26.1-08-01, 26.1-08-06, 26.1-08-06.1, 26.1-08-07, 26.1-08-08, 26.1-08-09, 26.1-08-10, 26.1-08-11, 26.1-08-12, 26.1-08-13, and 57-38-30.4 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota; and to repeal sections 26.1-08-02, 26.1-08-03, and 26.1-08-04 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection ~~4~~ 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this

subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

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

Unfair referral. An insurer, insurance producer, or third-party administrator referring an individual employee to the association, or arranging for an individual employee to apply to the association for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

SECTION 3. 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 comprehensive health association ~~created by section 26.1-08-03~~ of North Dakota.
2. "~~Association~~ Benefit plan" means insurance policy coverage offered by the association through the lead carrier.
3. "~~Association~~ Benefit plan premium" means the charge for membership in ~~the~~ an association benefit plan based on the benefits provided in section 26.1-08-06 and determined pursuant to section 26.1-08-08.
4. "Board" means the association board of directors.
5. "Credible coverage" means, with respect to an individual, coverage of the individual provided under a group health plan; health insurance; a medical care program of the Indian health service or of a tribal organization; a state health benefits risk pool; a public health plan as defined in federal regulations; or health care coverage under section 5(e) of the federal Peace Corps Act [Pub. L. 87-293; 75 Stat. 613; 22 U.S.C. 2504(e)].
6. "Eligible ~~person~~ individual" means ~~either:~~
   ~~a.~~ ~~An~~ an individual ~~who has been a resident of this state for a period of six months and meets the enrollment requirements of~~ eligible for association benefit plan coverage as specified under section 26.1-08-12~~; or~~

~~b. An individual who:~~

~~(1) Is currently a resident of this state;~~

~~(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~~.

7. "Governmental plan" has the same meaning as provided under section 3(32) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] and as may be provided under any federal governmental plan.

8. "Group health plan" has the same meaning as employee welfare benefit plan as provided under section 3(1) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] to the extent that the plan provides medical care, and including items and service paid for as medical care to employees or the employees' dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

~~5.~~ 9. "Health ~~benefits~~ insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits ~~offered on an indemnity or prepaid~~

~~basis which~~ that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible ~~person~~ individual, chiropractic care. The term does not include:

a. Coverage only for accident, disability income insurance, or any combination of the two;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for onsite medical clinics; or

h. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

~~6.~~ 10. "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~~, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

~~7.~~ 11. "Lead carrier" means the insurance company selected by the ~~association~~ board to administer the association ~~plan~~ the benefit plans.

12. "Medicare" means coverage under both parts A and B of title XVIII of the federal Social Security Act [Pub. L. 89-97; 79 Stat. 291; 42 U.S.C. 1395 et seq.].

13. "Participating member" means any insurance company that is licensed or authorized to do business in this state which has an annual premium volume of accident and health insurance contracts derived from or on behalf of residents in the previous calendar year of at least one hundred thousand dollars.

~~8.~~ 14. "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.~~ 15. "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~~ that 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.~~ 16. "Qualified plan" means those health benefit plans certified by the ~~commissioner~~ board as providing the minimum benefits required by section 26.1-08-06 for a qualified comprehensive plan, or section 26.1-08-06.1 for ~~a qualified medicare supplement plan~~ the over age sixty-five and disabled supplements, or 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.].

17. "Resident" means an individual who has been a legal resident of this state for a minimum of one hundred eighty-three days. However, for a federally defined eligible individual, there is no minimum length of residency requirement.

18. "Significant break in coverage" means a period of sixty-three or more consecutive days during all of which the individual does not have any credible coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

SECTION 4. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Board of directors.

1. The board consists of the commissioner; the state health officer; the director of the office of management and budget; one senator appointed by the president of the senate of the legislative assembly; one representative appointed by the speaker of the house of representatives of the legislative assembly; and one individual from

each of the three participating member insurance companies of the association with the highest annual premium volumes of accident and health insurance contracts as provided by the commissioner, verified by the lead carrier, and approved by the board.

2. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.

3. The costs of conducting the meetings of the association and the board is borne by the association.

4. The commissioner shall fill vacancies in the board. The commissioner, for cause, may remove board members.

SECTION 5. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Powers and duties of commissioner and board - Fees.

1. The lead carrier shall operate the association subject to the supervision and control of the board.

2. The board shall:

   a. Formulate general policies to advance the purposes of this chapter;

   b. Approve the association's contract with the lead carrier;

   c. Approve the benefit plans;

   d. Approve the benefit plan premiums;

   e. Establish and modify from time to time, as appropriate, agents' referral fees;

   f. Approve the annual operating budget and any assessments to the participating members;

   g. Approve independent annual audits to assure the general accuracy of the financial date submitted by the lead carrier for the association;

   h. Develop and implement a program to publicize the existence of the association, the eligibility requirement, and procedures for enrollment and to maintain public awareness of the association;

   i. Approve bylaws and operating rules;

j. Exempt, by a two-thirds majority vote, an applicant from the preexisting condition provisions of section 26.1-08-12 when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life; and

k. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.

3. The commissioner, board, and lead carrier employees are not liable for any obligations of the association.

4. The commissioner may establish additional powers and duties of the board and may adopt rules necessary and proper for the association and to implement this chapter.

SECTION 6. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Operation of the association. The association may:

1. Exercise the powers granted to insurance companies under the laws of this state.

2. Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessment due the association.

3. Take such legal action as necessary:

a. To avoid the payment of improper claims against the association or the coverage provided by or through the association;

b. To recover any amounts erroneously or improperly paid by the association;

c. To recover any amounts paid by the association as a result of mistake of fact or law; or

d. To recover other amounts due the association.

4. Enter contracts with the insurance companies, similar associations in other states, or other persons for the performance of administrative functions.

5. Establish administrative and accounting procedures for the operation of the association.

6. Provide for the reinsuring of risks incurred as a result of issuing the coverages required by individuals covered by the association benefit plans.

7. Provide for the administration by the association of policies, which are reinsured pursuant to subsection 6.

8. Issue benefit plans for coverage in accordance with the requirements of sections 26.1-08-06 and 26.1-08-06.1.

9. Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

SECTION 7. 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~~ Comprehensive benefit plan.

1. A plan of health coverage is a qualified comprehensive plan if it otherwise meets the requirements established by chapters 26.1-36 and 26.1-36.4 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 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 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 a 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 a 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 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.~~ The benefit plan must offer comprehensive health care coverage to every eligible individual. The coverage to be issued by the association, its schedule of benefits, exclusions, and other limitations must be established by the lead carrier and subject to the approval of the board.

3. In establishing the benefit plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate. Benefit levels, deductibles,

coinsurance factors, copayments, exclusions, and limitations may be applied as determined to be generally reflective of health insurance coverage provided in the state.

4. The coverage may include deductibles of not less than five hundred dollars per individual per benefit period.

5. The coverage must include a limitation of three thousand dollars per individual on the total annual out-of-pocket expenses for services covered under this subsection.

6. Any coverage or combination of coverages through the association may not exceed a lifetime maximum benefit of one million dollars for an individual.

7. The coverage may include cost-containment measures and requirements, including preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost-effective.

8. The coverage may include preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

9. Coverage must include 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.

10. Coverage must include substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.

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

12. The coverage must include organ transplants as approved by the board.

13. The association must be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under an association benefit plan must be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or

no fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. The association must have a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.

14. Covered expenses for the service or articles specified in this subsection do not include:

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

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

c. 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.

d. Care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services under medicare.

e. Any charges for organ transplants unless approval is received from the board.

15. A qualified benefit plan also must offer the eligible individual the choice of an annual deductible of not less than one thousand dollars per individual instead of that provided in subsection 4.

SECTION 8. AMENDMENT. Section 26.1-08-06.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06.1. ~~Qualified medicare~~ Over age sixty-five and disabled supplement ~~plan~~ plans. A ~~qualified medicare~~ supplement plan ~~includes medicare supplement plans A and F. These plans are available to~~ must include over age sixty-five supplement one; over age sixty-five supplement six; disabled supplement one; and disabled supplement six for individuals who are eligible for medicare by reason of age or disability. Any coverage or combination of coverages through the association may not exceed a maximum benefit of one million dollars for an individual.

SECTION 9. AMENDMENT. Section 26.1-08-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-07. Approval and filing of benefit plans. The ~~association or the~~ lead carrier shall file with the commissioner, following approval from the board, all benefit plans, brochures, and other materials required to be approved to be offered under this chapter. The commissioner shall approve or disapprove any form within sixty days of receipt.

SECTION 10. AMENDMENT. Section 26.1-08-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-08. ~~Association~~ Benefit plan premium. The schedule of premiums to be charged eligible ~~persons~~ individuals for ~~membership in the association~~ a benefit plan must be established by the ~~association~~ lead carrier and approved by the board, but may not exceed one hundred thirty-five percent of the ~~average~~ individual premium rates charged ~~by the five largest insurers with the largest individual qualified plan of insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided by all insurers annually at the request of the commissioner. The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer and the rates charged by the insurer for each type of plan offered by the insurer and any other information the commissioner considers as necessary. The commissioner shall utilize generally acceptable actuarial principles and structurally compatible rates~~ for similar coverage throughout the state. If similar coverage is not offered by other insurance carriers, premium rates for actuarial equivalent benefit plans offered by other insurers in the state must be provided by the commissioner and utilized by the lead carrier to determine association rates for the benefit plans.

SECTION 11. AMENDMENT. Section 26.1-08-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-09. ~~Operation of association plan~~ Participating members.

1. ~~Upon certification as an eligible person in the manner provided by section 26.1-08-12, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.~~ There is established a comprehensive health association with participating membership consisting of

those insurance companies, licensed or authorized to do business in this state, with an annual premium volume of accident and health insurance contracts, derived from or on behalf of residents in the previous calendar year, of at least one hundred thousand dollars, as determined by the commissioner.

~~2. Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier may be used to pay claims and not more than twelve and one-half percent may be used for payment of the lead carrier's direct and indirect expenses as specified in section 26.1-08-10.~~ All participating members shall maintain their membership in the association, as a condition for writing policies in this state.

3. ~~Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.~~

~~4.~~ Each participating member of the association which is liable for state income tax or state premium tax shall share the losses due to claims and administrative expenses ~~and meeting expenses under subsection 2 of section 26.1-08-03~~ of the association ~~plan~~. The difference between the total claims expense of the association ~~plan~~ and the ~~premium payments allocated to the payment of benefits~~ benefit plan premiums received is the liability of ~~those association~~ the participating members ~~that are liable for state income tax or state premium tax~~. Such ~~association~~ participating members shall share in the excess costs of the association ~~plan~~ in an amount equal to the ratio of a participating member's total annual premium volume for accident and health insurance ~~charges,~~ received from or on behalf of state residents, to the total accident and health insurance premium ~~contract charges~~ volume received by ~~association~~ all of the participating members ~~that are liable for state income taxes or state premium taxes from or on behalf of state residents,~~ as determined by the ~~commissioner~~ lead carrier and approved by the board.

4. Each member's liability may be determined retroactively and payment of the assessment is due within thirty days after notice of the assessment is given.

Failure by a member to tender to the lead carrier on behalf of the association the full amount assessed within thirty days of notification by the ~~association~~ lead carrier is grounds for termination of membership.

SECTION 12. AMENDMENT. Section 26.1-08-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-10. Administration of the association ~~plan~~.

1. ~~Any participating member of the association shall submit to the commissioner the policies which are being proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~ Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier may be used to pay claims.
2. ~~The association shall select policies and contracts by a member or members of the association to be the association plan. The association shall select one lead carrier to issue the qualified plans. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board.~~ Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association or be allocated to reduce benefit plan premiums.
3. ~~The lead carrier shall perform all administrative and claims payment functions required by this section.~~ The lead carrier ~~shall provide these services~~ agreement must continue for a period of at least three years, unless a request to terminate is approved by the ~~association and the commissioner~~ board. The ~~association and the commissioner~~ board shall approve or deny a request to terminate within ninety days of its receipt. A failure to make a final decision on a request to terminate within the specified period is deemed an approval. ~~The association shall invite submissions of policy forms from members of the association, including the lead carrier, six months prior to the expiration of each three-year period. The association shall follow subsection 2 in selecting a lead carrier for the subsequent~~

~~three-year period, or if a request to terminate is approved on or before the end of the three-year period.~~ The agreement will be automatically renewed until either party terminates the agreement.

4. ~~The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.~~

~~5.~~ ~~The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association shall determine the specific information to be contained in the report prior to the effective date of the association plan.~~

~~6.~~ ~~The lead carrier shall pay all claims pursuant to this chapter and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.~~

~~7.~~ The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the association ~~plan~~. ~~The association shall approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles.~~ Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~8.~~ 5. The lead carrier is, when carrying out its duties under this chapter, an agent of the association and the ~~commissioner~~ board, and is civilly liable for its actions, subject to the laws of this state.

6. The lead carrier shall:

a. Perform all administrative and claims payment functions required under this chapter.

b. Determine eligibility of individuals requesting coverage through the association.

c. Provide all eligible individuals involved in the association an individual certificate setting forth a statement as to the insurance protection to which the individual is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

d. Pay all claims under this chapter and indicate that the association paid the claims. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

e. Establish a premium billing procedure for collection of premium from individuals covered by the association.

f. Obtain approval from the board for all benefit plans issued.

g. Submit regular reports to the board regarding the operation of the association.

h. Submit to the participating companies, board, and director, on a semiannual basis a report of the operation of the association.

i. Verify premium volumes of all accident and health insurers in the state.

j. Determine and collect assessments.

k. Perform such functions relating to the association as may be assigned to it.

SECTION 13. AMENDMENT. Section 26.1-08-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-11. Solicitation of eligible ~~persons~~ individuals.

1. The association, pursuant to a plan approved by the ~~commissioner~~ board, shall disseminate appropriate information to the residents of this state regarding the existence of the association ~~plan~~, the benefit plans, and the means of enrollment. Means of communication may include use of the press, radio, electronic mail, internet, and television, as well as publication in appropriate state offices and publications.
2. The association and board shall devise and implement means of maintaining public awareness of ~~this chapter~~ the association and shall administer this chapter in a manner ~~which~~ that facilitates public participation ~~in the association plan~~.

3. All licensed accident and health insurance producers may engage in the selling or marketing of qualified association benefit plans. The lead carrier shall pay an insurance producer's referral fee of twenty-five dollars to each licensed accident and health insurance insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid to the lead carrier from moneys received as premiums for the association benefit plan.

4. Every insurance company ~~which~~ that rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the association ~~plan~~, requirements for being accepted in it, and the procedure for applying to it.

SECTION 14. 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~~ Eligibility.

1. The association ~~plan~~ must be open for enrollment by eligible ~~persons~~ individuals. ~~A person is eligible and may enroll in the plan by submission of an application to the lead carrier.~~ Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must ~~provide~~:
   a. ~~The~~ Provide the name, address, and age of the applicant~~, and~~.
   b. Provide the length of applicant's residence in this state.
   ~~b.~~ c. ~~The~~ Provide the name, address, and age of spouse and children, if any, ~~if they are to be insured~~.
   ~~c. 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~~ Provide a designation of coverage desired.
   e. Be accompanied by premium and evidence to prove eligibility.
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~~ this section

or forward the eligible ~~person~~ individual 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 or the day following the date shown on the written rejection or refusal, if the applicant otherwise complies with this chapter.

3. An eligible ~~person~~ individual 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.~~ An individual may qualify to enroll in the association for benefit plan coverage as:

a. An applicant A:

(1) An individual who has been a resident of this state for one hundred eighty-three days and continues to be a resident of the state who has

received from at least one insurance carrier within one hundred eighty-three days of the date of application, one of the following:

(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Refusal by an insurer to issue insurance except at the rate exceeding the association benefit rate.

(2) Is not eligible for the state's medical assistance program.

b. An applicant B:

(1) An individual who meets the federally defined eligibility guidelines as follows:

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

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

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

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

(e) Has not had the most recent qualifying previous coverage described in subparagraph b terminated for nonpayment of premiums or fraud; and

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

(2) Is and continues to be a resident of the state.

(3) Is not eligible for the state's medical assistance program.

c. An applicant over age sixty-five or disabled:

(1) An individual who is eligible for medicare by reason of age or disability and has been a resident of this state for one hundred eighty-three days and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty-three days of the date of application, one of the following:

(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Refusal by an insurer to issue insurance except at the rate exceeding the association benefit rate.

(2) Is not eligible for the state's medical assistance program.

5. The board and lead carrier shall develop a list of medical or health conditions for which an individual must be eligible for association coverage without applying for health insurance coverage under subdivisions a and c of subsection 4. Individuals with written evidence of the existence or history of any medical or health conditions on the approved list may not be required to provide written evidence of rejection, refusal, or substantially reduce coverage.

6. A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection 4 is not sufficient evidence to qualify.

7. An eligible individual may have insurance coverage, other than the state's medical assistance program, with an additional commercial insurer; however, the association will reimburse eligible claim costs as payer of last resort.

8. Each resident dependent of an individual who is eligible for association coverage is also eligible for association coverage.

9. Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition is also eligible for association coverage.

10. Preexisting conditions.

a. Association coverage must exclude charges or expenses incurred during the first one hundred eighty days following the effective date of coverage for any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the ninety days immediately preceding the date of the application.

b. Association coverage must exclude charges or expenses incurred for maternity during the first two hundred seventy days following the effective date of coverage.

c. Any individual with coverage through the association 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 eighty days of coverage.

11. Waiting periods do not apply to an individual who:

a. Is receiving nonelective treatment or procedures for a congenital or genetic disease.

b. Is receiving nonelective treatment or procedures and 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 date of the application.

c. Has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 4.

d. Has obtained coverage as an eligible person under subdivision a of subsection 4, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and provided the association application is made within sixty-three days of termination of the qualifying previous coverage.

12. An individual is not eligible for coverage through the association if:

a. The individual is determined to be eligible for health care benefits under the state's medical assistance program.

b. The individual has previously terminated association coverage unless twelve months have lapsed since such termination. This limitation does not apply to an applicant who is a federally defined eligible individual.

c. The association has paid out one million dollars in benefits on behalf of the individual.

d. The individual is an inmate or resident of a public institution. This limitation does not apply to an applicant who is a federally defined eligible individual.

e. The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer.

13. A period of credible coverage is not counted with respect to the enrollment of an individual who seeks coverage under this chapter is after such period and before the enrollment date, the individual experiences a significant break in coverage which is more than sixty-three days.

SECTION 15. AMENDMENT. Section 26.1-08-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-13. Termination of coverage. Coverage under this chapter terminates:

1. Upon request of the covered person.
2. For failure to pay the required premium subject to a thirty-one-day grace period.
3. When the one million dollar lifetime maximum benefit amount has been reached ~~under subdivision a of subsection 1 of section 26.1-08-06~~.
4. If the covered person qualifies for health benefits under ~~other plans or policies~~ the state's medical assistance program.
5. If the covered individual physically resides outside this state for more than one hundred eighty-two days of each ~~plan~~ calendar year, except for an ~~association participant~~ individual who is absent from the state for a verifiable medical reason as determined by the ~~association~~ board.

SECTION 16. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Exempt from premium tax. The association is exempt from the insurance premium tax imposed under section 26.1-03-17.

SECTION 17. AMENDMENT. Section 57-38-30.4 of the North Dakota Century Code is amended and reenacted as follows:

57-38-30.4. Income tax credit for comprehensive health association assessments. The amount of any assessment paid by any member of the comprehensive health association under subsection ~~4~~ 3 of section 26.1-08-09 is a credit against the state income tax for which a member may be liable for the year which the assessment was paid.

SECTION 18. REPEAL. Sections 26.1-08-02, 26.1-08-03, and 26.1-08-04 of the North Dakota Century Code are repealed.