

**Sixty-first Legislative Assembly of North Dakota  
In Regular Session Commencing Tuesday, January 6, 2009**

SENATE BILL NO. 2318  
(Senators Dever, Erbele, Heckaman, J. Lee)  
(Representatives Kreidt, L. Meier)

AN ACT to create and enact section 26.1-18.1-03.1 of the North Dakota Century Code, relating to bond requirements for qualified programs of all-inclusive care for the elderly; and to amend and reenact section 26.1-18.1-01 of the North Dakota Century Code, relating to the regulation of qualified programs of all-inclusive care for the elderly.

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

**SECTION 1. AMENDMENT.** Section 26.1-18.1-01 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-18.1-01. Definitions.**

1. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, and diagnostic and therapeutic radiological services.
2. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
3. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.
4. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.
5. "Deductible" means the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment.
6. "Enrollee" means an individual who is covered by a health maintenance organization.
7. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contractholder.
8. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.
9. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.
10. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.
11. "Group contractholder" means the person to which a group contract has been issued.

12. "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both. However, a qualified program of all-inclusive care for the elderly is not a health maintenance organization.
13. "Health maintenance organization producer" means an insurance producer, as defined in section 26.1-26-02, who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise holds out to the public as such.
14. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.
15. "Insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
16. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.
17. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities do not include fully subordinated debt.
18. "Participating provider" means a provider as defined in subsection ~~20~~ 19 who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.
19. ~~"Person" means any natural or artificial person including individuals, partnerships, associations, trusts, or corporations.~~
- ~~20.~~ "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.
20. "Qualified program of all-inclusive care for the elderly" means a program that:
  - a. Is sponsored by a religious or charitable organization that is itself or is controlled by an entity organized under section 501(c)(3) of the Internal Revenue Code [26 U.S.C. 501(c)(3)];
  - b. Has been approved by the centers for medicare and medicaid services of the United States department of health and human services to operate, and is currently operating as, a program of all-inclusive care for the elderly; and
  - c. Has revenues from private pay sources which do not exceed ten percent of the program's total revenues.
21. "Replacement coverage" means the benefits provided by a succeeding carrier.
22. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.
23. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's

insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

**SECTION 2.** Section 26.1-18.1-03.1 of the North Dakota Century Code is created and enacted as follows:

**26.1-18.1-03.1. Bond or insurance requirement.** A qualified program of all-inclusive care for the elderly that operates in this state shall maintain a surety bond, in the amount of two hundred fifty thousand dollars. Any surety bond issued under this section must authorize recovery by the commissioner on behalf of any person in this state that sustained damages as the result of unfair practices, conviction of fraud, or failure by a qualified program of all-inclusive care for the elderly to perform a contractual obligation owed to the person.

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President of the Senate

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Speaker of the House

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Secretary of the Senate

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Chief Clerk of the House

This certifies that the within bill originated in the Senate of the Sixty-first Legislative Assembly of North Dakota and is known on the records of that body as Senate Bill No. 2318.

Senate Vote:      Yeas    47            Nays    0            Absent    0

House Vote:      Yeas    91            Nays    0            Absent    3

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Secretary of the Senate

Received by the Governor at \_\_\_\_\_ M. on \_\_\_\_\_, 2009.

Approved at \_\_\_\_\_ M. on \_\_\_\_\_, 2009.

\_\_\_\_\_  
Governor

Filed in this office this \_\_\_\_\_ day of \_\_\_\_\_, 2009,

at \_\_\_\_\_ o'clock \_\_\_\_\_ M.

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Secretary of State