Sixty-sixth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1106

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to create and enact chapter 26.1-36.7 of the North Dakota Century Code, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study; and to declare an emergency.

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 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 against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is 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. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36.7-01. Definitions.

For purposes of this chapter, unless the context otherwise requires:

1. "Association" means the reinsurance association of North Dakota.
2. "Board" means the board of directors of the reinsurance association of North Dakota.
3. "Earned group health benefit plan premiums" means premium owed to an insurer for a period of time during which the insurer has been liable to cover claims for an insured pursuant to the terms of a group health benefit plan issued by the insurer.
4. "Future losses" means reserves for claims incurred but not reported.
5. "Group health benefit plan" means a health benefit plan offered through an employer, or an association of employers, to more than one individual employee.
6. "Health benefit plan" means any hospital and medical expense-incurred policy or certificate, 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 that pay the costs of or provide medical, surgical, or hospital care.
   a. "Health benefit plan" does not include any one or more of the following:
      (1) Coverage only for accident or disability income insurance, or any combination of the two;
      (2) Coverage issued as a supplement to liability insurance;
      (3) Liability insurance, including general liability insurance and automobile liability insurance;
      (4) Workforce safety and insurance or similar workers' compensation insurance;
      (5) Automobile medical payment insurance;
      (6) Credit-only insurance;
      (7) Coverage for onsite medical clinics;
      (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; and
      (9) Self-funded~~, single employer~~ plans ~~not regulated by the state~~.

b. "Health benefit plan" does not include the following benefits if the benefits 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, or community-based care, or any combination of this care; and

(3) Other similar limited benefits specified under federal regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. "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 insurance coverage 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 sponsor:

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

(2) Hospital indemnity or other fixed indemnity insurance.

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

(1) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];

(2) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

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

7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include short-term, limited-duration health insurance as defined by section 26.1-36-49.

8. "Insured" means an individual who is insured by a health benefit plan.

9. "Insurer" means an entity authorized to write health benefit plans or that provides health benefit plans in the state. The term includes an insurance company as defined in section 26.1-02-01, a nonprofit health service organization, a fraternal benefit society, and a health maintenance organization~~, a self-funded multiple employer welfare arrangement, a reinsurer that reinsures health insurance in this state, a third-party administrator, and any other entity providing health insurance coverage or health benefits which is subject to state insurance regulation.~~

~~10. "Medical stop-loss premiums" means amounts paid for health benefit plan insurance protection issued in this state providing reimbursement of all or a portion of medical or prescription claims in excess of a previously determined amount.~~

~~11.~~10. "Member insurer" means an insurer that offers individual health benefit plans and is actively marketing individual health benefit plans in this state.

~~12. "Third-party administrator" means an entity licensed in this state which is paying or otherwise processing health benefit plan claims on behalf of an insurer.~~

~~13. "Third-party administrator premium equivalents" means health benefit plan claims paid by the third-party administrator, administrative fees charged by the third-party administrator to process health benefit plan claims paid to in-state providers for North Dakota residents, and medical stop-loss premiums.~~

26.1-36.7-02. Waiver proposal and application.

1. The commissioner may develop a proposal for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148 119 Stat. 124; 42 U.S.C. 1801 et seq.].
2. On behalf of the state, in accordance with the proposal developed under subsection 1, the commissioner may submit an application the to the United States department of health and human services and to the United States secretary of the treasury. The commissioner may implement any federally approved waiver.

26.1-36.7-03. Reinsurance association of North Dakota.

1. The reinsurance association of North Dakota is established as a nonprofit legal entity. As a condition of writing health insurance business in this state, an insurer that has issued or administered a group health benefit plan within the previous twelve months

or is actively marketing or administering a group health benefit plan in this state shall participate in the association.

2. The association may begin operation on either:

   a. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the state's innovation waiver application has been approved by the federal government pursuant to section 1332 of the federal Patient Protection and Affordable Care Act [Pub L. 111-148 Stat. 124; 42 U.S.C. 1801 et seq.]; or

   b. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the Patient Protection and Affordable Care Act [Pub. L. 111-148] has been repealed, amended, or finally adjudicated by a court of law with jurisdiction over North Dakota as invalid or in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

3. If the federal funding associated with an approved innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148 Stat. 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the commissioner may cease or suspend operations of the reinsurance association of North Dakota beginning on the January first following the date the commissioner notifies the board that federal funding has been terminated or otherwise discontinued.

26.1-36.7-04. Board of directors.

1. The association is governed by the board of directors of the reinsurance association of North Dakota.

2. The board consists of the state health officer, one senator appointed by the majority leader of the senate of the legislative assembly, one representative appointed by the speaker of the house of representatives of the legislative assembly, one individual from each of the four insurers of the association with the highest annual market share as determined by annual market share reports of health benefit plans provided by the commissioner annually, and two nonvoting, members from the insurance department appointed by the commissioner.

3. 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.

4. The costs of conducting the meetings of the association and the board are borne by the association.

5. For cause, the commissioner may remove any board member representing one of the four insurers.

26.1-36.7-05. Powers and duties of commissioner and board.

1. The commissioner shall:

   a. Perform all functions necessary for the association to carry out the purposes of this chapter; and

   b. Approve any assessments to the insurers writing or otherwise issuing group health benefit plans. A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment.

2. The board shall:

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

   b. Schedule and approve independent biennial audits in order to:

      (1) Ensure claims are being processed appropriately and only include services covered by the individual health benefit plan for the contracted rates; and

      (2) Verify that the assessment base is accurate and that the appropriate percentage was used to calculate the assessment;

   c. Approve bylaws and operating rules; and

   d. 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 and the members of the board are not liable for any obligations of the association.

26.1-36.7-06. Assessments against insurers.

1. For the purpose of providing the funds necessary to carry out the purposes of the association under this chapter, the commissioner shall assess insurers writing or otherwise issuing group health benefit plans based on the insurer's group health benefit plan premium written in this state ~~and based on third-party administrator~~

~~premium equivalents in this state~~. The assessment must be paid quarterly within forty-five days of the end of the previous quarter on all earned group health benefit plan premiums ~~and third-party administrator premium equivalents~~ for the previous calendar quarter. An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due.

2. The commissioner may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the commissioner. The commissioner may use any reasonable method of estimating an insurer's group health benefit plan premium ~~and third-party administrator premium equivalent~~ if the specific number is not reported to the commissioner. ~~The assessments are due not less than thirty days after written notice to the insurers and accrue interest at twelve percent per annum on and after the due date.~~

3. Any federal funding obtained by the association must be used to reduce the assessments of insurers writing or otherwise issuing group health benefit plans pursuant to this section.

4. Before April second of each year, the association shall determine and report to the board the association's net gains or net losses for the previous calendar year.

5. Before April sixteenth of each year, the association shall provide an estimate to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

6. Before May second of each year, the board may provide a recommendation to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

7. An insurer may apply to the commissioner for a deferral of all or part of an assessment imposed by the association under this section. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited

from reinsuring any person through the association until such time as the insurer pays the assessments.

8. The board shall use any surplus, including any interest earned on the surplus, to:

a. Offset future losses;

b. Reduce future assessments to insurers writing or otherwise issuing group health benefit plans; or

c. Pay off a line of credit issued pursuant to section 26.1-36.7-07.

9. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the commissioner may use any power granted to the commissioner by this title to collect any unpaid assessment.

26.1-36.7-07. Bank of North Dakota line of credit.

The Bank of North Dakota shall extend to the association a line of credit not to exceed twenty-five million dollars. The association shall repay the line of credit from assessments against insurers writing or otherwise issuing group health benefit plans in this state or from other funds appropriated by the legislative assembly. The association may access the line of credit to the extent necessary to provide reimbursements to member insurers as required by this chapter.

26.1-36.7-08. Reinsurance.

For claims of an insured which total one hundred thousand dollars to one million dollars incurred per plan year, a member insurer must be reinsured by the association at seventy-five percent of the member insurer's responsibility for claims incurred by the insured pursuant to the terms of an individual's nongrandfathered individual health benefit plan.

26.1-36.7-09. Reimbursement of member insurer.

For nongrandfathered individual health benefit plans issued or renewed after the November second preceding to the date the association begins operation, a member insurer may seek reimbursement from the association and the association shall reimburse the member insurer pursuant to the provisions of section 26.1-36.7-08 to the extent the claims incurred by the

insured and submitted by the member insurer to the association are eligible for coverage and reimbursement according to the terms of insured's individual health benefit plan.

26.1-36.7-10. Rulemaking.

The commissioner may adopt rules for the implementation and administration of this chapter.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM TREND. During the 2019-20 interim, the legislative management shall study ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-seventh legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure.