

Sixty-sixth
Legislative Assembly
of North Dakota

ENGROSSED HOUSE BILL NO. 1106

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

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

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

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

9 2. An insurance company, nonprofit health service corporation, health maintenance
10 organization, or prepaid legal service organization subject to the tax imposed by
11 subsection 1 is entitled to a credit against the tax due for the amount of any
12 assessment paid as a member of a comprehensive health association under
13 subsection 3 of section 26.1-08-09 for which the member may be liable for the year in
14 which the assessment was paid, a credit against the tax due for the amount of any
15 assessment paid as a member of the reinsurance association of North Dakota under
16 section 26.1-36.7-06 for which the member may be liable for the year in which the
17 assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against
18 the tax due for an amount equal to the examination fees paid to the commissioner
19 under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and
20 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem
21 taxes, whether direct or in the form of rent, on that proportion of premises occupied as
22 the principal office in this state for over one-half of the year for which the tax is paid.
23 The credits under this subsection must be prorated on a quarterly basis and may not
24 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 plans.

- 1 b. "Health benefit plan" does not include the following benefits if the benefits are
2 provided under a separate policy, certificate, or contract of insurance or are
3 otherwise not an integral part of the plan:
4 (1) Limited scope dental or vision benefits;
5 (2) Benefits for long-term care, nursing home care, home health care, or
6 community-based care, or any combination of this care; and
7 (3) Other similar limited benefits specified under federal regulations issued
8 under the federal Health Insurance Portability and Accountability Act of 1996
9 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].
10 c. "Health benefit plan" does not include the following benefits if the benefits are
11 provided under a separate policy, certificate, or contract of insurance; there is no
12 coordination between the provision of the benefits; and any exclusion of benefits
13 under any group health insurance coverage maintained by the same plan
14 sponsor, and the benefits are paid with respect to an event without regard to
15 whether benefits are provided with respect to such an event under any group
16 health plan maintained by the same sponsor:
17 (1) Coverage only for specified disease or illness; and
18 (2) Hospital indemnity or other fixed indemnity insurance.
19 d. "Health benefit plan" does not include the following if offered as a separate policy,
20 certificate, or contract of insurance:
21 (1) Medicare supplement health insurance as defined under section 1882(g)(1)
22 of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];
23 (2) Coverage supplemental to the coverage provided under chapter 55 of
24 United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces
25 medical and dental care; and
26 (3) Similar supplemental coverage provided under a group health plan.
27 7. "Individual health benefit plan" means a health benefit plan offered to individuals, other
28 than in connection with a group health benefit plan. The term does not include short-
29 term, limited-duration health insurance as defined by section 26.1-36-49.
30 8. "Insured" means an individual who is insured by a health benefit plan.

1 9. "Insurer" means an entity authorized to write health benefit plans or that provides
2 health benefit plans in the state. The term includes an insurance company as defined
3 in section 26.1-02-01, a nonprofit health service organization, a fraternal benefit
4 society, and a health maintenance organization.

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

7 **26.1-36.7-02. Waiver proposal and application.**

8 1. The commissioner may develop a proposal for an innovation waiver under section
9 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148 119
10 Stat. 124; 42 U.S.C. 1801 et seq.].

11 2. On behalf of the state, in accordance with the proposal developed under subsection 1,
12 the commissioner may submit an application the to the United States department of
13 health and human services and to the United States secretary of the treasury. The
14 commissioner may implement any federally approved waiver.

15 **26.1-36.7-03. Reinsurance association of North Dakota.**

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

21 2. The association may begin operation on either:

22 a. The January first following the date the commissioner certifies to the secretary of
23 state and the legislative council that the state's innovation waiver application has
24 been approved by the federal government pursuant to section 1332 of the federal
25 Patient Protection and Affordable Care Act [Pub L. 111-148 Stat. 124; 42 U.S.C.
26 1801 et seq.]; or

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

- 1 3. If the federal funding associated with an approved innovation waiver under section
2 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148 Stat.
3 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the
4 commissioner may cease or suspend operations of the reinsurance association of
5 North Dakota beginning on the January first following the date the commissioner
6 notifies the board that federal funding has been terminated or otherwise discontinued.

7 **26.1-36.7-04. Board of directors.**

- 8 1. The association is governed by the board of directors of the reinsurance association of
9 North Dakota.
10 2. The board consists of the state health officer, one senator appointed by the majority
11 leader of the senate of the legislative assembly, one representative appointed by the
12 speaker of the house of representatives of the legislative assembly, one individual
13 from each of the four insurers of the association with the highest annual market share
14 as determined by annual market share reports of health benefit plans provided by the
15 commissioner annually, and two nonvoting, members from the insurance department
16 appointed by the commissioner.
17 3. Members of the board may be reimbursed from the moneys of the association for
18 expenses incurred by the members due to their service as board members, but may
19 not otherwise be compensated by the association for board services.
20 4. The costs of conducting the meetings of the association and the board are borne by
21 the association.
22 5. For cause, the commissioner may remove any board member representing one of the
23 four insurers.

24 **26.1-36.7-05. Powers and duties of commissioner and board.**

- 25 1. The commissioner shall:
26 a. Perform all functions necessary for the association to carry out the purposes of
27 this chapter; and
28 b. Approve any assessments to the insurers writing or otherwise issuing group
29 health benefit plans. A group health benefit plan issued pursuant to chapter
30 54-52.1 is exempt from the assessment.
31 2. The board shall:

- 1 a. Formulate general policies to advance the purposes of this chapter;
- 2 b. Schedule and approve independent biennial audits in order to:
- 3 (1) Ensure claims are being processed appropriately and only include services
- 4 covered by the individual health benefit plan for the contracted rates; and
- 5 (2) Verify that the assessment base is accurate and that the appropriate
- 6 percentage was used to calculate the assessment;
- 7 c. Approve bylaws and operating rules; and
- 8 d. Provide for other matters as may be necessary and proper for the execution of
- 9 the commissioner's and board's powers, duties, and obligations.
- 10 3. The commissioner and the members of the board are not liable for any obligations of
- 11 the association.

12 **26.1-36.7-06. Assessments against insurers.**

- 13 1. For the purpose of providing the funds necessary to carry out the purposes of the
- 14 association under this chapter, the commissioner shall assess insurers writing or
- 15 otherwise issuing group health benefit plans based on the insurer's group health
- 16 benefit plan premium written in this state. The assessment must be paid quarterly
- 17 within forty-five days of the end of the previous quarter on all earned group health
- 18 benefit plan premiums for the previous calendar quarter. An assessment not paid
- 19 within forty-five days of the end of the previous quarter accrues interest at twelve
- 20 percent per annum beginning on the date due.
- 21 2. The commissioner may verify the amount of each insurer's assessment based on
- 22 annual statements and other reports determined to be necessary by the
- 23 commissioner. The commissioner may use any reasonable method of estimating an
- 24 insurer's group health benefit plan premium if the specific number is not reported to
- 25 the commissioner.
- 26 3. Any federal funding obtained by the association must be used to reduce the
- 27 assessments of insurers writing or otherwise issuing group health benefit plans
- 28 pursuant to this section.
- 29 4. Before April second of each year, the association shall determine and report to the
- 30 board the association's net gains or net losses for the previous calendar year.

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

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

7 7. An insurer may apply to the commissioner for a deferral of all or part of an assessment
8 imposed by the association under this section. The commissioner may defer all or part
9 of the assessment if the commissioner determines the payment of the assessment
10 would place the insurer in a financially impaired condition. If all or part of the
11 assessment is deferred, the amount deferred must be assessed against other insurers
12 in a proportionate manner consistent with this section. The insurer that receives a
13 deferral remains liable to the association for the amount deferred and is prohibited
14 from reinsuring any person through the association until such time as the insurer pays
15 the assessments.

16 8. The board shall use any surplus, including any interest earned on the surplus, to:
17 a. Offset future losses;
18 b. Reduce future assessments to insurers writing or otherwise issuing group health
19 benefit plans; or
20 c. Pay off a line of credit issued pursuant to section 26.1-36.7-07.

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

27 **26.1-36.7-07. Bank of North Dakota line of credit.**

28 The Bank of North Dakota shall extend to the association a line of credit not to exceed
29 twenty-five million dollars. The association shall repay the line of credit from assessments
30 against insurers writing or otherwise issuing group health benefit plans in this state or from
31 other funds appropriated by the legislative assembly. The association may access the line of

1 credit to the extent necessary to provide reimbursements to member insurers as required by
2 this chapter.

3 **26.1-36.7-08. Reinsurance.**

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

8 **26.1-36.7-09. Reimbursement of member insurer.**

9 For nongrandfathered individual health benefit plans issued or renewed after the November
10 second preceding to the date the association begins operation, a member insurer may seek
11 reimbursement from the association and the association shall reimburse the member insurer
12 pursuant to the provisions of section 26.1-36.7-08 to the extent the claims incurred by the
13 insured and submitted by the member insurer to the association are eligible for coverage and
14 reimbursement according to the terms of insured's individual health benefit plan.

15 **26.1-36.7-10. Rulemaking.**

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

18 **SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM**

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

26 **SECTION 4. EXPIRATION DATE.** This Act is effective through July 31, 2021, and after that
27 date is ineffective.

28 **SECTION 5. EMERGENCY.** This Act is declared to be an emergency measure.