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FIRST ENGROSSMENT

Fifty-sixth
Legislative Assembly
of North Dakota

ENGROSSED HOUSE BILL NO. 1178

Introduced by

Industry, Business and Labor Committee

(At the request of the Commissioner of Insurance)

A BILL for an Act to create and enact sections 26.1-01-07.6 and 26.1-26.4-04.2 of the North Dakota Century Code, relating to medicare provider-sponsored organizations and health care service utilization review; and to amend and reenact section 26.1-26.4-02, subdivision d of subsection 1 of section 26.1-36-04, subsection 22 of section 26.1-36.3-01, subdivision e of subsection 3 of section 26.1-36.3-06, subsection 6 of section 26.1-36.3-06, section 26.1-36.4-03, subsection 8 of section 26.1-47-01, and section 26.1-47-02 of the North Dakota Century Code, relating to health care service utilization review, accident and health insurance, small employer health insurance, and preferred provider organizations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-01-07.6 of the North Dakota Century Code is created and enacted as follows:

26.1-01-07.6. Medicare provider-sponsored organizations. The commissioner of insurance shall adopt rules relating to provider-sponsored organizations as defined in section 4001 of the Balanced Budget Act of 1997 [Pub. L. 105-33; 111 Stat. 312; 42 U.S.C. 1395 et seq.].

SECTION 2. AMENDMENT. Section 26.1-26.4-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-02. Definitions. For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the commissioner of insurance.
2. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment,

reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.

3. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

4. "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.

~~4.~~ 5. "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

~~5.~~ 6. "Utilization review agent" means any person or entity performing utilization review, except:

a. An agency of the federal government; or

b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services.

SECTION 3. Section 26.1-26.4-04.2 of the North Dakota Century Code is created and enacted as follows:

26.1-26.4-04.2. Utilization review - Duty of health care insurers. A health care insurer that contracts with another entity to perform utilization review on its behalf remains responsible to ensure that all the requirements of this chapter are met to the same extent the health care insurer would be if it performed the utilization review itself.

SECTION 4. AMENDMENT. Subdivision d of subsection 1 of section 26.1-36-04 of the North Dakota Century Code is amended and reenacted as follows:

d. A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed

prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a preexisting disease or physical condition for which ~~first manifested itself in the five years immediately prior to~~ medical advice or treatment was received by the person during the two-year period before the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the end of the two-year period commencing on the effective date of the person's coverage.

SECTION 5. AMENDMENT. Subsection 22 of section 26.1-36.3-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

22. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:
    a. The individual:
        (1) Was covered under qualifying previous coverage at the time of the initial enrollment;
        (2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and
        (3) Requests enrollment within ~~sixty-three~~ thirty days after termination of the qualifying previous coverage.
    b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.
    c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

d. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.

SECTION 6. AMENDMENT. Subdivision e of subsection 3 of section 26.1-36.3-06 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a ~~basic or standard~~ health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

SECTION 7. AMENDMENT. Subsection 6 of section 26.1-36.3-06 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

6. ~~This section~~ Subsection 1 does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

SECTION 8. AMENDMENT. Section 26.1-36.4-03 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-03. Limits on preexisting condition exclusions. An insurer may impose a preexisting condition exclusion only if:

1. The exclusion relates to a condition, regardless of the cause of the condition, for which medical diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of the person's coverage.
2. The exclusion extends for a period of not more than twelve months after the effective date of coverage. A group policy may impose an eighteen-month

preexisting condition to a late enrollee, as the term late enrollee is defined in section 26.1-36.3-01.

SECTION 9. AMENDMENT. Subsection 8 of section 26.1-47-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

8. "Preferred provider ~~agreement~~ arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter.

SECTION 10. AMENDMENT. Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements. Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:
   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.
   b. Include mechanisms which are designed to minimize the cost of the health benefit plan. These mechanisms may:
      (1) Provide for the review and control of utilization of health care services.
      (2) Establish a procedure for determining whether health care services rendered are medically necessary.
   c. Include mechanisms which are designed to preserve the quality of health care.
   d. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.
   e. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.
   f. Provide that either party terminating the contract without cause provide the other party at least sixty days advance written notice of the termination.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

3. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

4. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.

5. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.