Sixty-first
Legislative Assembly
of North Dakota

SENATE BILL NO. 2214

Introduced by

Senators J. Lee, Dever, Warner

Representatives N. Johnson, Kaldor, Weisz

A BILL for an Act to amend and reenact section 26.1-08-12 of the North Dakota Century Code, relating to comprehensive health association of North Dakota eligibility provisions.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-12. Eligibility.

1. The association must be open for enrollment by eligible individuals. Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must~~:~~
   ~~a. Provide the name, address, and age of the applicant.~~
   ~~b. Provide the length of applicant's residence in this state.~~
   ~~c. Provide the name, address, and age of spouse and children, if any.~~
   ~~d. Provide a designation of coverage desired.~~
   ~~e. Be~~ be completed fully and 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 this section or forward the eligible individual a notice of acceptance and billing information.
3. At the option of the eligible individual, association coverage is effective:
   a. For an eligible individual applying under subsection 10 or 11, on the signature date of the application.
   b. For an eligible individual applying under subparagraph a of paragraph 1 of subdivision a of subsection 5 or under subparagraph a of paragraph 1 of subdivision c of subsection 5:

(1) On the day following the date shown on the written evidence;

(2) On the signature date of the application, if it is at least one day and less than one hundred eighty days following the date shown on the written evidence; or

(3) On any date after the signature date of the application if the date is at least one day and less than one hundred eighty days following the date shown on the written evidence.

c. For an eligible individual applying under subparagraph b or c of paragraph 1 of subdivision a of subsection 5 or under subparagraph b or c of paragraph 1 of subdivision c of subsection 5:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application but less than one hundred eighty days following the date shown on the written evidence.

d. For an eligible individual applying under subdivision b or d of subsection 5:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application, but less than sixty-four days following termination of previous coverage.

e. For an eligible individual applying under subsection 6:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application, but less than one hundred eighty days following the date shown on the written evidence from a medical professional.

4. An eligible individual may not purchase more than one policy from the association.

5. An individual may qualify to enroll in the association for benefit plan coverage as:

a. A traditional applicant:

(1) An individual who has been a resident of this state and continues to be a resident of the state who has received from at least one insurance carrier within one hundred eighty 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) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.

(2) Is not enrolled in health benefits with the state's medical assistance program.

b. A Health Insurance Portability and Accountability Act of 1996 applicant:

(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, medicaid, 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 medicare or a group health benefit plan as the term is defined in section 26.1-36.3-01;

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

(e) Has not had the most recent qualifying previous coverage described in subparagraph a 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 enrolled in health benefits with the state's medical assistance program.

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

(1) An individual who is eligible for medicare by reason of age or disability and has been a resident of this state and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty 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) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.

(2) Is not enrolled in health benefits with the state's medical assistance program.

d. A Trade Adjustment Assistance Reform Act of 2002 applicant:

(1) A trade adjustment assistance, pension benefit guarantee corporation individual applicant who:

(a) Has three or more months of qualifying previous health insurance coverage at the time of application;

(b) Has applied for coverage within sixty-three days of the termination of the individual's previous health insurance coverage;

(c) Is and continues to be a resident of the state;

(d) Is not enrolled in the state's medical assistance program;

(e) Is not imprisoned under federal, state, or local authority; and

(f) Does not have health insurance coverage through:

[1] The applicant's or spouse's employer if the coverage provides for employer contribution of fifty percent or more of the cost of coverage of the spouse, the eligible individual, and the dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan.

[2] A state's children's health insurance program, as defined under section 50-29-01.

[3] A government plan.

[4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care.

[5] Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.] relating to health insurance for the aged and disabled.

(2) Coverage under this subdivision may be provided to an individual who is eligible for health insurance coverage through the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer contribution is less than fifty percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

6. 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 5. 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 or refusal, a rate that exceeds the association rates, or substantially reduced coverage.

7. 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~~ 5 is not sufficient evidence to qualify.

8. A traditional applicant, as specified under subdivision a of subsection 5, 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.

9. An individual who is eligible for association coverage as specified under subdivision c of subsection 5 may not have more than one policy that is a

supplement to part A or part B of medicare relating to health insurance for the aged and disabled. The individual may obtain association coverage as a traditional applicant as specified under subdivision a of subsection 5 which is concurrent with a supplement policy offered by a commercial carrier. However, the association will reimburse eligible claims as payer of last resort.

10. ~~Each resident dependent of an individual who is eligible for association coverage~~ If an individual is enrolled in association coverage, that individual's resident dependent is also eligible for association coverage.

11. ~~Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition~~ If an individual is enrolled in association coverage, that individual's resident spouse is also eligible for association coverage.

12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth. This coverage is not available to an applicant under subdivision c of subsection 5.

13. 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 one hundred eighty days immediately preceding the signature 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.

d. A preexisting condition may not be imposed on an individual who is eligible under subdivision b or d of subsection 5.

14. Waiting periods do not apply ~~to an individual who~~:

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

b. ~~Has~~ To an individual who has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 5.

c. ~~Has~~ To an individual who has obtained coverage as an eligible person under subdivision a or c of subsection 5, 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.

d. ~~Has~~ To an individual who has obtained coverage as an eligible individual under subdivision d of subsection 5.

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

a. The individual is enrolled in health benefits with 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 as defined under subdivision b of subsection 5.

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

d. The individual is imprisoned under federal, state, or local authority. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subdivision b of subsection 5.

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. However, this subdivision does not apply if the individual's premiums are paid for or

reimbursed under a program established under the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933].

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