21.0013.02000

Sixty-seventh
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

Legislative Management

(Health Care Committee)

A BILL for an Act to create and enact sections 26.1-36.4-03.2 and 26.1-36.4-03.3 of the North Dakota Century Code, relating to hospital and medical insurance pre-existing conditions and guaranteed issue; and to amend and reenact section 26.1-36.3-01, subsection 2 of section 26.1-36.3-06, and sections 26.1-36.4-02 and 26.1-36.4-04 of the North Dakota Century Code, relating to small employer employee health insurance and hospital and medical insurance guaranteed issue and guaranteed availability.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36.3-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-01. Definitions.

As used in this chapter and section 26.1-36-37.2, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the insurance commissioner, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
2. "Affiliate" or "affiliated" means ~~any entity or~~a person ~~who~~that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified ~~entity or~~ person.
3. "Association" means, with respect to health insurance coverage offered in this state, an association that:
   a. Has been actively in existence for at least five years;

b. Has been formed and maintained in good faith for purposes other than obtaining insurance;

c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee or dependent of an employee;

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member; and

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

4. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

5. "Case characteristics" means demographic or other objective characteristics of a small employer ~~that~~which are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.

6. "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

7. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.

8. "Control" ~~is as defined in~~has the same meaning as provided under section 26.1-10-01.

9. "Dependent" means a spouse~~,~~; an unmarried child, including a dependent of an unmarried child, under the age of twenty-two~~,~~; an unmarried child who is a full-time student under the age of twenty-six and who is financially dependent upon the enrollee~~,~~; and an unmarried child, including a dependent of an unmarried child, of any age who is medically certified as disabled and dependent upon the enrollee as set forth in section 26.1-36-22.

10. "Eligible employee" means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

11. "Enrollee" means ~~a person~~an individual covered under a small employer health benefit plan.

12. "Established geographic service area" means a geographic area, as approved by the insurance commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

13. "Governmental plan" means an employee welfare benefit plan as defined in section 3(32) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.

14. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent ~~that~~ the plan provides medical care as defined in this section and including items and services paid for as medical care to employees or ~~their~~ dependents of the employees as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this chapter:

    a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent ~~that~~ the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to ~~their~~ dependents of the present or former partners, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, must be treated as an employee welfare benefit plan ~~which~~that is a group health benefit plan;

    b. In the case of a group health benefit plan, the term "employer" also includes the partnership in relationship to any partner; and

c. In the case of a group health benefit plan, the term "participant" also includes:

(1) In connection with a group health benefit plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(2) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive benefits under the plan or the beneficiaries may be eligible to receive any benefit.

15. "Guaranteed availability" means a health plan is guaranteed to be available to an applicant regardless of health status, age, or income.

16. "Guaranteed issue" means a health plan is guaranteed to be issued to an applicant regardless of health status, age, or income.

17. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract.

b. "Health benefit plan" does not include one or more, or any combination of, the following:

(1) Coverage only for accident~~,~~ or disability income insurance, or any combination ~~thereof~~of accident and disability income insurance;

(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 insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance.

c. "Health benefit plan" does not include the following benefits if ~~they~~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, community-based care, or any combination thereof; or

(3) Such other similar, limited benefits as are specified in federal regulations.

d. "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 benefit plan 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 plan sponsor:

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

(2) Hospital indemnity or other fixed indemnity insurance.

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

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and

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

f. A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance shall comply with the following:

(1) File with the insurance commissioner on or before March first of each year a certification that contains:

(a) A statement from the carrier certifying ~~that~~ the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases ~~when~~if premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.

(2) ~~When~~If the policy or certificate is offered for the first time in this state on or after August 1, 1993, file with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

~~16.~~18. "Health carrier" or "carrier" means any entity that provides health insurance in this state. For purposes of this chapter, health carrier includes an insurance company, a prepaid limited health service corporation, a fraternal benefit society, a health maintenance organization, nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

~~17.~~19. "Health status-related factor" means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including condition arising out of acts of domestic violence; or

h. Disability.

~~18.~~20. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

~~19.~~21. "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 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.

~~20.~~22. "Medical care" means amounts paid for:

a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in subdivision a; and

c. Insurance covering medical care referred to in subdivisions a and b.

~~21.~~23. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

~~22.~~24. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

~~23.~~25. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~24.~~26. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~25.~~27. "Producer" means insurance producer.

~~26.~~28. a. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under any of the following:

~~a.~~ (1) A group health benefit plan;

~~b.~~ (2) A health benefit plan;

~~c.~~ (3) Medicare;

~~d.~~ (4) Medicaid;

~~e.~~ (5) Civilian health and medical program for uniformed services;

~~f.~~ (6) A medical care program of the Indian health service or of a tribal organization;

~~g.~~ (7) A state health benefit risk pool, including coverage issued under chapter 26.1-08;

~~h.~~ (8) A health plan offered under 5 U.S.C. 89;

~~i.~~ (9) A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government;

~~j.~~ (10) A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and

~~k.~~ (11) A state's children's health insurance program funded through title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].

b. The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan".

~~27.~~29. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~28.~~30. "Reinsuring carrier" means a small employer carrier ~~which~~that reinsures individuals or groups with the program.

~~29.~~31. "Restricted network provision" means any provision of a health benefit plan ~~that~~which conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered ~~into~~ a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.

~~30.~~32. "Small employer" means, in connection with a group health plan with respect to a calendar and a plan year, an employer ~~who~~that employed an average of at least two but not more than fifty eligible employees on business days during the preceding calendar year and ~~who~~which employs at least two employees on the first day of the plan year.

~~31.~~33. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

SECTION 2. AMENDMENT. Subsection 2 of section 26.1-36.3-06 of the North Dakota Century Code is amended and reenacted as follows:

2. Health benefit plans covering small employers must comply with the following:
   a. A health benefit plan may impose a pre-existing condition exclusion only if:
      (1) The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;
      (2) The exclusion extends for a period of not more than ~~twelve~~six months after the effective date of coverage;
      (3) The exclusion does not relate to pregnancy as a pre-existing condition; and
      (4) The exclusion does not treat genetic information as a pre-existing condition in the absence of a diagnosis of a condition related to such information.
   b. A small employer carrier shall reduce any time period applicable to a pre-existing condition exclusion or limitation period by the aggregate of periods the individual was covered by qualifying previous coverage, if any, if the qualifying previous coverage was continuous until at least ~~sixty-three~~ninety days ~~prior to~~before the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a group health benefit plan may not be taken into account in

determining the period of continuous coverage. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan. Small employer carriers shall credit coverage by either a standard method or an alternative method. The commissioner shall adopt rules for crediting coverage under the standard and alternative method. These rules must be consistent with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any federal rules adopted pursuant ~~thereto~~to the federal Act.

c. A health benefit plan may exclude coverage for late enrollees for ~~the greater of eighteen months or for an eighteen-month pre-existing condition exclusion~~up to six months; however, if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period may not exceed ~~eighteen~~six months from the date the individual enrolls for coverage under the health benefit plan.

d. (1) Except as provided in this subdivision, a small employer carrier shall apply requirements used to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees who are applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (a) Except as provided in subparagraph b, a small employer carrier, in applying minimum participation requirements with respect to a small employer, may not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met. For purposes of determining the applicable percentage of participation under this subparagraph only, individual health benefit plans are not included in the definition of "qualifying existing coverage" under section 26.1-36.3-01.

(b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.

(4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

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 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 3. AMENDMENT. Section 26.1-36.4-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-02. Definitions.

As used in this chapter, the definitions in section 26.1-36.3-01 apply, unless the context otherwise requires. In addition:

1. "Guaranteed issue" means an individual health plan is guaranteed to be issued to an applicant regardless of health status, age, or income.
2. "Individual health plan" has the same meaning as provided under section 26.1-36-02.2.

3. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization that provides a plan of health insurance or health benefits subject to state insurance regulation.

~~2.~~4. "Policy" means any health benefit plan as defined in section 26.1-36.3-01, whether offered on a group or individual basis. The term does not include short-term limited-duration health insurance plans offered in the individual market.

~~3.~~5. "Short-term limited-duration health insurance plan", except as required by the Health Insurance Portability and Accountability Act of 1996, is defined by section 26.1-36-49.

SECTION 4. Section 26.1-36.4-03.2 of the North Dakota Century Code is created and enacted as follows:

26.1-36.4-03.2. Individual health plans - Pre-existing conditions - Limitations.

An insurer may not impose a pre-existing condition exclusion on an individual health plan unless:

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 insured's coverage; and
2. The exclusion extends for not more than six months after the effective date of coverage.

SECTION 5. Section 26.1-36.4-03.3 of the North Dakota Century Code is created and enacted as follows:

26.1-36.4-03.3. Individual health plans - Guaranteed issue.

If an insurer offers an individual health plan, the insurer shall offer all the insurer's individual health plans to all applicants as guaranteed issue.

SECTION 6. AMENDMENT. Section 26.1-36.4-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-04. Portability of insurance policies.

An insurer shall reduce any time period applicable to a pre-existing condition, for a policy by the aggregate of periods the individual was covered by qualifying previous coverage, if the qualifying previous coverage as defined in section 26.1-36.3-01 is continuous until at least ~~sixty-three~~ninety days before the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a health benefit plan may not be taken into

account in determining the period of continuous coverage. Insurers shall credit coverage in the same manner as provided by section 26.1-36.3-06 and the rules adopted by the commissioner ~~pursuant thereto~~under that section.