Sixty-sixth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2102

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to create and enact chapter 26.1-53.1 of the North Dakota Century Code, relating to discount plans; and to repeal chapter 26.1-53 of the North Dakota Century Code, relating to discount medical plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-53.1 of the North Dakota Century Code is created and enacted as follows:

26.1-53.1-01. Definitions.

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

1. "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
2. "Ancillary services" includes audiology, dental, vision, mental health, substance abuse, chiropractic, and podiatry services.
3. "Control", "controlled by", or "under control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by section 26.1-10-04, that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such

determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

4. "Direct primary care" means any private contract between a provider and consumer for services associated with that provider.

5. "Discount plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers members the access to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount plan from those providers. The term includes a discount prescription drug plan. The term does not include:

a. A plan that does not charge a membership, payment, dues, other consideration, or other fee to use the discount plan;

b. Any product otherwise regulated under title 26.1;

c. Direct primary care;

d. A patient access program; or

~~d.~~e. A Medicare prescription drug plan.

~~5.~~6. "Discount plan organization" means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for discount plan members to providers of medical or ancillary services and the right to receive medical or specialty services from those providers at a discount. It is the organization that contracts with providers, provider networks, or other discount plan organizations to offer access to medical or specialty services at a discount and determines the charge to discount plan members.

~~6.~~7. "Discount prescription drug plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides members the access to providers of pharmacy services and the right to receive discounts on pharmacy services provided under the discount prescription drug plan from those providers.

~~7.~~8. "Facility" means an institution providing medical or ancillary services or a health care setting. The term includes:

a. A hospital or other licensed inpatient center;

b. An ambulatory surgical or treatment center;

c. A skilled nursing center;

d. A residential treatment center;

e. A rehabilitation center; and

f. A diagnostic, laboratory, or imaging center.

~~8.~~9. "Health care professional" means a physician, pharmacist, or other health care practitioner who is licensed, accredited, or certified to perform specified medical or ancillary services within the scope of the professional's license, accreditation, certification, or other appropriate authority consistent with state law.

~~9.~~10. "Health insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or medical or ancillary services.

~~10.~~11. "Marketer" means a person that markets, promotes, sells, or distributes a discount plan, including a private label entity that places the entity's name on and markets or distributes a discount plan pursuant to a marketing agreement with a discount plan organization.

~~11.~~12. "Medical services" means any maintenance care of, or preventive care for, the human body, or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. The term includes physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric services, laboratory services, medical equipment and supplies, pharmacy services, and ancillary services.

~~12.~~13. "Medicare prescription drug plan" means a plan that provides Medicare part D prescription drug benefit in accordance with the requirements of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173].

~~13.~~14. "Member" means any individual who pays fees, dues, charges or other consideration for the right to receive the benefits of a discount plan or discount prescription drug plan.

~~14.~~15. "Patient access program" means a voluntary program sponsored by a pharmaceutical manufacturer, or a consortium of pharmaceutical manufacturers, which provide free or discounted health care products directly to low-income or uninsured individuals either through a discount card or direct shipment.

~~15.~~16. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

~~16.~~17. "Pharmacy services" includes pharmaceutical supplies and prescription drugs.

~~17.~~18. "Provider" means any health care professional or facility that has contracted, directly or indirectly, with a discount plan organization to provide medical or ancillary services to members.

~~18.~~19. "Provider network" means an entity that negotiates, directly or indirectly, with a discount plan organization on behalf of more than one provider to provide medical or ancillary services to members.

26.1-53.1-02. Application.

1. This chapter applies to all discount plan organizations conducting business in this state.
2. A discount plan organization that is a health insurer licensed pursuant to title 26.1:
   a. Is not required to be registered as a discount plan organization. However, any of the organization's affiliates that operate as a discount plan organization in this state shall comply with all provisions of this chapter and must be registered as a discount plan organization.
   b. Is required to comply with sections 26.1-53.1-14 through 26.1-53.1-21.

26.1-53.1-03. Registration requirements for a discount plan organization - Fees.

1. Before doing business in or from this state as a discount plan organization, a discount plan organization:
   a. Must be authorized to transact business in this state through the secretary of state; and

b. Must be registered by the commissioner to operate as a discount plan organization.

2. An application for registration under this chapter must be filed with the commissioner on a form prescribed by the commissioner.

3. The application must demonstrate, set forth, or be accompanied by the following:

a. The five hundred dollar application fee;

b. A list of the names, addresses, official positions, and biographical information of each individual responsible for conducting the applicant's affairs, including each:

(1) Member of the board of directors, board of trustees, executive committee, or other governing board or committee;

(2) Officer;

c. A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in subdivision b;

d. All marketing materials to be used in connection with marketing a discount plan in this state;

e. A description of member complaint procedures to be established and maintained by the applicant;

f. A copy of the applicant's cancellation and refund policy;

g. The name and address of the applicant's agent for service of process, notice, or demand, or if not domiciled in this state, a duly executed instrument appointing the commissioner and the commissioner's successors, the applicant's attorney upon whom all process in any action or proceeding against the applicant may be served; and

h. Any other information the commissioner may reasonably require.

4. The department may request a copy of the form of all contracts to be made or sold in this state or to be made between the applicant and any providers or provider networks regarding provision of medical or ancillary services to members.

5. The department may request a copy of the form of any contract between the applicant and any person or other entity for the performance on the applicant's behalf of any function, including marketing, administration, enrollment, investment management, and contracting for the provision of medical or ancillary services to cardholders.

6. After the receipt of an application filed pursuant to this section, the commissioner shall review the application and notify the applicant of any deficiencies in the application.

7. After receipt of a completed application, the commissioner shall:

a. Register the applicant as a discount plan if the commissioner is satisfied the applicant has met the following:

(1) The requirements of this section; and

(2) The ownership, control, and management of the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount plan organization beneficial to discount plan members; or

b. Deny the registration application and state the grounds for denial.

8. Registration is effective for one year, unless before expiration the registration is renewed in accordance with this subsection or suspended or revoked in accordance with section 26.1-53.1-12.

9. Not later than March first of each year, the discount plan organization shall submit:

a. Updated information to anything provided pursuant to subsections 3, 4, and 5 and section 26.1-53.1-23; and

b. The renewal fee of two hundred fifty dollars.

10. The commissioner shall renew the registration of each discount plan organization that meets the requirements of this chapter and pays the appropriate renewal fee.

26.1-53.1-04. Exception to registration for providers giving discounts to own patients.

A provider that provides discounts to the provider's own patients, without any cost or fee of any kind to the patient, is not required to obtain and maintain registration under this chapter as a discount plan organization.

26.1-53.1-05. Surety bond.

Each registered discount plan organization shall maintain in force a surety bond in the organization's own name in an amount not less than thirty-five thousand dollars to be used in the discretion of the commissioner to protect the financial interest of members. The bond must be issued by an insurance company licensed to do business in this state. Initially, a copy of the bond or a statement identifying the depository, trustee, and account number of the surety

account, and for renewal proof of annual renewal of the bond or maintenance of the surety account, must be filed with the commissioner.

26.1-53.1-06. Surety bonds not subject to levy by claimants.

Except for the commissioner, the assets or securities held in this state as a deposit pursuant to section 26.1-53.1-05 are not subject to levy by a judgment creditor or other claimant of the discount plan organization.

26.1-53.1-07. Internet website to be established.

Before registration by the commissioner, each discount plan organization shall establish an internet website. The internet website must have an up-to-date list of names and addresses of the providers with which the organization has contracted directly or through a provider network. The internet website address must be displayed prominently on all of the discount plan organization's advertisements, marketing materials, brochures, and discount plan cards.

26.1-53.1-08. Investigation by commissioner.

Within a reasonable time after receipt of a properly completed application for registration under this chapter, the commissioner may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter the commissioner believes necessary or advisable to determine compliance with this chapter or for the protection of the public.

26.1-53.1-09. Reporting of actions.

A discount plan organization shall report to the commissioner any administrative action taken against the organization in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report must include a copy of the order, consent to order, or other relevant legal documents.

26.1-53.1-10. Nonrenewal, suspension, or revocation.

The commissioner may suspend the authority of a discount plan organization to enroll new members or refuse to renew, suspend, or revoke a discount plan organization's registration if, after notice to the registrant and hearing, the commissioner finds that any of the following conditions exist:

1. The discount plan organization is not operating in compliance with this chapter;
2. The discount plan organization has advertised, merchandised, or attempted to merchandise the organization's services in such a manner as to misrepresent the

organization's services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising;

3. The discount plan organization is not fulfilling the organization's obligations as a discount plan organization; or

4. The continued operation of the discount plan organization would be hazardous to the organization's members.

26.1-53.1-11. Winding up of affairs.

If the registration of a discount plan organization is surrendered, revoked, or not renewed, the discount plan organization shall proceed, immediately following surrender, or the effective date of the order of revocation or, in the case of a nonrenewal, the date of expiration of the registration, to wind up the organization's affairs transacted under the registration. The discount plan organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

26.1-53.1-12. Duration of suspension - Conditions for reinstatement.

The commissioner shall, in the commissioner's order suspending the authority of the discount plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount plan organization before reinstatement of the organization's registration to enroll members. The commissioner may rescind or modify the order of suspension before the expiration of the suspension period. Registration of a discount plan organization may not be reinstated unless requested by the discount plan organization. The commissioner may not grant the request for reinstatement if the commissioner finds the circumstances for which the suspension occurred still exist or are likely to continue.

26.1-53.1-13. Examination or investigation of discount plan organization - Expenses.

The commissioner may examine or investigate the business and affairs of any discount plan organization to protect the interests of the residents of this state for any potential violations of this chapter or as the commissioner deemed necessary. The discount plan organization shall produce any requested information and documentation within twenty days of such request. The discount plan organization that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount plan organization to pay the expenses is grounds for denial of registration or revocation of

registration to operate as a discount plan organization. The discount plan organization is subject to the provisions of section 26.1-04-03 and nothing in this chapter may be construed to discharge any requirements imposed by section 26.1-04-03.

26.1-53.1-14. Charges and fees - Refund requirements.

1. A discount plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount plan.
2. If a member cancels the member's membership in the discount plan organization within the first thirty days after the date of receipt of the signed consumer contract or agreement, the member shall receive a reimbursement of all periodic charges.
3. If the discount plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount plan organization shall make a pro rata reimbursement of all periodic charges to the member.

26.1-53.1-15. Bundled products.

1. If a discount plan is bundled with other products, the bundled product must clearly identify the discount plan component separately from each other component.
2. A discount plan organization that is a health insurer licensed pursuant to title 26.1 which provides a discount plan product that is incidental to the insured product is not subject to this section.
3. If a discount plan is bundled with an insurance product, the discount plan organization or marketer selling such product must be licensed pursuant to chapter 26.1-26.

26.1-53.1-16. Provider agreements.

1. A discount plan organization must have a written provider agreement with all providers offering medical or ancillary services to the organization's members. The written provider agreement may be entered directly with the provider or indirectly with a provider network to which the provider belongs.
2. A provider agreement between a discount plan organization and a provider must provide the following:
   a. A list of the medical or ancillary services and products to be provided at a discount;
   b. The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

c. That the provider will not charge members more than the discounted rates.

3. A provider agreement between a discount plan organization and a provider network must require that the provider network have written agreements with the provider network's providers which:

a. Contain the provisions described in subsection 2;

b. Authorize the provider network to contract with the discount plan organization on behalf of the provider; and

c. Require the provider network to maintain an up-to-date list of the provider network's contracted providers and to provide the list on a monthly basis to the discount plan organization.

4. A provider agreement between a discount plan organization and an entity that contracts with a provider network must require that the entity, in the entity's contract with the provider network, require the provider network to have written agreements with the provider network's providers which comply with subsection 3.

5. The discount plan organization shall maintain a copy of each active provider agreement into which the organization has entered.

26.1-53.1-17. Marketing requirements.

1. A discount plan organization may market directly or contract with other marketers for the distribution of the organization's product.

2. The discount plan organization must have an executed written agreement with a marketer before the marketer's marketing, promoting, selling, or distributing the discount plan.

3. The agreement between the discount plan organization and the marketer must prohibit the marketer from using advertising, marketing materials, brochures, and discount plan cards without the discount plan organization's approval in writing.

4. The discount plan organization must be bound by and responsible for the activities of a marketer which are within the scope of the marketer's agency relationship with the organization, or are otherwise approved by or under the direction and control of the organization.

5. Before use, a discount plan shall approve in writing any advertisements, marketing materials, brochures, and discount cards used by marketers to market, promote, sell or distribute the discount plan.

26.1-53.1-18. Advertisements to be truthful and not misleading.

Any advertisements, marketing materials, brochures, discount plan cards, and any other communications of a discount plan organization provided to prospective members and members must be truthful and not misleading in fact or implication. An advertisement, marketing material, brochure, discount plan card, or other communication is misleading in fact or in implication if the communication has a capacity or tendency to mislead or deceive based on the overall impression the communication is reasonably expected to create within the segment of the public to which the communication is directed.

26.1-53.1-19. Prohibited conduct.

A discount plan organization may not:

1. Except as otherwise provided in this chapter, or as a disclaimer of any relationship between discount plan benefits and insurance, or as a description of an insurance product connected with a discount plan, use the term "insurance" in any advertisement, marketing material, brochure, or discount plan cards;
2. Use in any advertisements, marketing materials, brochures, or discount plan cards the terms "health plan", "coverage", "copay", "copayments", "deductible", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization", or other terms in a manner that could reasonably mislead an individual into believing the discount plan is health insurance;
3. Use language in any advertisements, marketing materials, brochures, or discount plan cards with respect to being licensed or registered by the state insurance department in a manner that could reasonably mislead an individual into believing the discount plan is insurance or has been endorsed by the state;
4. Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount plan;
5. Have restrictions on access to discount plan providers, including, except for hospital services, waiting periods and notifications periods; or

6. Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided, unless the discount plan organization has an active certificate of authority to act as a third-party administrator in accordance with chapter 26.1-27.

26.1-53.1-20. Required disclosures.

1. A discount plan organization or marketer shall disclose clearly and conspicuously in writing to any prospective member and on any advertisements, marketing materials, or brochures relating to a discount plan:
   a. The plan is a discount plan and is not insurance coverage;
   b. The range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;
   c. Unless the discount plan organization has an active certificate of authority to act as a third-party administrator as described in subsection 6 of 26.1-53.1-19, that the plan does not make payments to providers for the medical or ancillary services received under the discount plan;
   d. The plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount plan organization; and
   e. The toll-free telephone number and internet website address for the registered discount plan organization for prospective members and members to obtain additional information about and assistance on the discount plan and up-to-date lists of providers participating in the discount plan.
2. If the initial contact with a prospective member is by telephone, the disclosures required under subsection 1 must be made orally and be included in the initial written materials that describe the benefits under the discount plan provided to the prospective or new member.
3. In addition to the disclosures required under subsection 1, each discount plan organization or marketer shall provide to each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount plan,

including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount plan.

26.1-53.1-21. Written agreement with member.

Each new member must be provided a written document that contains the terms and conditions of the discount plan that clearly provides:

1. The name of the member;
2. The benefits to be provided under the discount plan;
3. Any processing fees and periodic charges associated with the discount plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;
4. The mode of payment of any processing fees and period charges, such as monthly or quarterly, and procedures for changing the mode of payment;
5. Any limitations, exclusions, or exceptions regarding the receipt of discount plan benefits;
6. Any waiting periods for certain medical or ancillary services under the discount plan;
7. Procedures for obtaining discounts under the discount plan, such as requiring members to contact the discount plan organization to make an appointment with a provider on the member's behalf;
8. Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;
9. Renewal, termination, and cancellation terms and conditions;
10. Procedures for adding new members to a family discount plan, if applicable;
11. Procedures for filing complaints under the discount plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact the plan member's state insurance department; and
12. The name and mailing address of the registered discount plan organization where the member can make inquiries about the plan, send cancellation notices, and file complaints.

26.1-53.1-22. Notice of change in name or address.

Each discount plan organization shall provide the commissioner at least thirty days' advance notice of any change in the discount plan organization's name, principal business address, mailing address, or internet website address.

26.1-53.1-23. Annual reports.

1. A discount plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner no later than March first.
2. The report must include:
   a. If different from the initial application for registration or at the time of renewal of registration or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount plan organization, including any possible conflict of interest;
   b. The number of discount plan members in the state; and
   c. Any other information relating to the performance of the discount plan organization which the commissioner may require.
3. Any discount plan organization that fails to file an annual report in the form and within the time required by this section:
   a. Accrues monetary penalties of:
      (1) Up to five hundred dollars each day for the first ten days during which the violation continues; and
      (2) Up to one thousand dollars each day after the first ten days during which the violation continues; and
   b. Upon notice by the commissioner, lose the organization's authority to enroll new members or do business in this state while the violation continues.

26.1-53.1-24. Civil penalties for violation of chapter.

In addition to or in lieu of any applicable denial, suspension, or revocation of registration, any person violating this chapter may, after hearing, be subject to a civil fine not to exceed ten thousand dollars for each violation. The fine may be collected and recovered in an action brought in the name of the state.

26.1-53.1-25. Designation of compliance officer.

Each discount plan organization shall designate and provide the commissioner with the name, address, and telephone number of the discount plan organization's compliance officer responsible for ensuring compliance with this chapter.

26.1-53.1-26. Record filing and retention requirements.

1. Upon demand by the commissioner, a discount plan organization shall file with the commissioner a list of prospective member fees and charges associated with the discount plan.
2. A copy of every form to be used by a discount plan organization, including the form for the written document demonstrating membership in the plan and all advertising, marketing materials and brochures, must be retained by such organization and available for inspection by the commissioner for at least five years from the date on which the form was last used.

26.1-53.1-27. Rulemaking.

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

26.1-53.1-28. Application to existing discount plan organizations.

A person doing business in this state as a discount plan organization on or before the effective date of this chapter has six months following the effective date of this Act to come into compliance with the requirements of this chapter.

SECTION 2. REPEAL. Chapter 26.1-53 of the North Dakota Century Code is repealed.