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Fifty-fifth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT with Senate Amendments

ENGROSSED HOUSE BILL NO. 1168

Introduced by

Industry, Business and Labor Committee

(At the request of the Commissioner of Insurance)

A BILL for an Act to create and enact section 26.1-36.4-03.1 of the North Dakota Century Code, relating to preexisting condition provisions; to amend and reenact sections 26.1-08-01, 26.1-08-04, 26.1-08-06, 26.1-08-06.1, 26.1-08-07, 26.1-08-12, subsection 3 of section 26.1-08-13, sections 26.1-36.3-01, 26.1-36.3-05, 26.1-36.3-06, subsection 1 of section 26.1-36.3-11, sections 26.1-36.4-02, 26.1-36.4-03, 26.1-36.4-04, and 26.1-36.4-05 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota, small group health insurance, and individual health insurance; to repeal section 26.1-08-05, relating to the comprehensive health association of North Dakota; to provide for application; to provide an effective date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-08-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Association" means the association created by section 26.1-08-03.
2. "Association plan" means insurance policy coverage offered by the association through the lead carrier.
3. "Association plan premium" means the charge for membership in the association plan based on the benefits provided in section ~~26.1-08-05 or~~ 26.1-08-06 and determined pursuant to section 26.1-08-08.
4. "Eligible person" means ~~an~~ either:
   a. An individual who has been a resident of this state for a period of six months and meets the enrollment requirements of section 26.1-08-12~~.~~; or
   b. An individual who:

(1) Is currently a resident of this state;

(2) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01, the most recent of which is coverage under a group health benefit plan, governmental plan, or church plan, as those terms are defined in section 26.1-36.3-01;

(3) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;

(4) Is not eligible for coverage under a group health benefit plan as that term is defined in section 26.1-36.3-01, medicare, or medicaid;

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

(6) Has not had the most recent qualifying previous coverage described in paragraph 2 terminated for nonpayment of premiums or fraud; and

(7) If offered the option, has elected continuation coverage under the Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage was exhausted.

5. "Health benefits" means benefits offered on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible person, chiropractic care.

6. ~~"Insurance company" means a company or organization operating pursuant to chapter 26.1-17, 26.1-18, or 26.1-36 and offering or selling accident and health insurance policies or health care or health service contracts. The term does not include a health service corporation operating under chapter 26.1-17 which does not write hospital or medical service contracts.~~ "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization selling group or individual hospital, medical, surgical, or major medical coverage.

7. "Lead carrier" means the insurance company selected by the association to administer the association plan.

8. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of individual policies or coverage under a nonprofit health service plan.

9. "Policy" means insurance, health care plan, health benefit plan as defined in section 26.1-36.3-01, or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage which is (a) limited to disability or income protection coverage, (b) automobile medical payment coverage, (c) supplemental to liability insurance, (d) designed solely to provide payment on a per diem basis, daily indemnity, or non-expense-incurred basis, or (e) credit accident and health insurance.

10. "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by section ~~26.1-08-05,~~ 26.1-08-06 for a qualified comprehensive plan, or section 26.1-08-06.1 for a qualified medicare supplement plan, or ~~the actuarial equivalent of those benefits~~ other plan developed by the board and certified by the commissioner as a qualified comprehensive plan.

SECTION 2. AMENDMENT. Section 26.1-08-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-04. ~~Minimum benefits of association~~ Association plan. The association ~~through its plan~~ shall offer ~~policies that provide at least the benefits of a number one and two qualified plan A and qualified plan B and a qualified medicare extended plan~~ "qualified plans" as defined in section 26.1-08-01.

SECTION 3. AMENDMENT. Section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06. Minimum benefits of a qualified comprehensive plan ~~B~~.

1. A plan of health coverage is a ~~number two~~ qualified comprehensive plan ~~B~~ if it otherwise meets the requirements established by chapter 26.1-36, and the other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:
   a. The minimum benefits for covered individuals must, subject to ~~this subdivision~~ subsection 2, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which must not be less than five

hundred dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than one million dollars.

b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

(3) Drugs requiring a physician's prescription.

(4) Services of a nursing home for not more than one hundred twenty days in a year if the services commence within fourteen days following confinement of at least three days in a hospital for the same condition.

(5) Service of a home health agency up to a maximum ~~of one hundred eighty~~ two hundred seventy visits per year.

(6) Use of radium or other radioactive materials.

(7) Oxygen.

(8) Anesthetics.

(9) Prostheses.

(10) Rental or purchase, as appropriate, of durable medical equipment.

(11) Diagnostic X-rays and laboratory tests.

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(13) Services of a physical therapist.

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(15) Substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.

c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include:

(1) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another accident and health insurance policy or medicare.

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(3) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(7) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(8) Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

2. ~~A plan of health coverage is a number one qualified plan B if it meets the requirements established by the laws of this state and provides for the payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which must not be less than one thousand dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than one million dollars~~ A qualified comprehensive plan also must offer the eligible person the choice of an annual deductible of not less than one thousand dollars per person instead of that provided in subdivision a of subsection 1.

SECTION 4. AMENDMENT. Section 26.1-08-06.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06.1. ~~Minimum benefits of a qualified~~ Qualified medicare ~~extended~~ supplement plan. ~~A qualified plan of health coverage must be established for eligible persons who are enrolled under title 1, part 1 of Public Law 89-97 and amendments thereto (Health Insurance for the Aged Act), known as medicare. The plan of health care coverage must supplement medicare part A and medicare part B and must provide for benefits consisting of that portion of medicare eligible expenses which are not paid by medicare part A and medicare part B. The plan of health coverage must provide benefits for medicare deductible and coinsurance amounts for medicare eligible expenses to the extent recognized as reasonable by medicare part A and medicare part B. No benefits may be provided for expenses that are not medicare eligible expenses.~~ A qualified medicare supplement plan is a medicare supplement plan F. This plan is available to individuals who are eligible for medicare by reason of age or disability.

SECTION 5. AMENDMENT. Section 26.1-08-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-07. ~~Certification of qualified~~ Approval of plans. ~~Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of this chapter, the commissioner shall make a determination within ninety~~

~~days as to whether the plan is qualified. All plans of health coverage must be labeled as "qualified plan A", "qualified plan B", or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans must indicate whether they are number one or two coverage plans.~~ The association or the lead carrier shall file with the commissioner all plans to be offered under this chapter. The commissioner shall approve or disapprove any form within sixty days of receipt.

SECTION 6. AMENDMENT. Section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-12. Enrollment by eligible person.

1. The association plan must be open for enrollment by eligible persons. A person is eligible and may enroll in the plan by submission of an application to the lead carrier. The application must provide:
   a. The name, address, and age of the applicant, and length of applicant's residence in this state.
   b. The name, address, and age of spouse and children, if any, if they are to be insured.
   c. ~~Written~~ For an "eligible person" under subdivision a of subsection 4 of section 26.1-08-01, written evidence that the applicant has been rejected for accident and health insurance, or that restrictive riders or a preexisting conditions limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least one insurance company within six months of the date of the application.
   d. A designation of coverage desired.
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 subsection 1 or forward the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt of the first month's association plan premium, and is retroactive to the date of the application, if the applicant otherwise complies with this chapter.
3. An eligible person may not purchase more than one policy from the association plan.

4. A person who obtains coverage pursuant to this section may not be covered for maternity during the first two hundred seventy days or any other preexisting condition during the first one hundred eighty days of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the date of the application. Any person with coverage through the association plan 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 eight days of coverage. This subsection does not apply to a person receiving nonelective procedures who has lost dependent status under a parent's or guardian's policy that has been in effect for the twelve-month period immediately preceding the filing of an application or to a person who is treated by nonelective procedures for a congenital or genetic disease. No preexisting condition exclusion or waiting period may be imposed under this subsection, or in the terms of the coverage obtained under this chapter, on an "eligible person" under subdivision b of subsection 4 of section 26.1-08-01. For an "eligible person" under subdivision a of subsection 4 of section 26.1-08-01, any preexisting condition exclusion must be reduced by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06.

SECTION 7. AMENDMENT. Subsection 3 of section 26.1-08-13 of the North Dakota Century Code is amended and reenacted as follows:

3. When the lifetime maximum benefit amount has been reached under ~~subsection 2 of section 26.1-08-05 or~~ subdivision a of subsection ~~2~~ 1 of section 26.1-08-06.

SECTION 8. 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 commissioner of insurance, 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 person who 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.

~~4.~~ 5. "Basic health benefit plan" means a lower cost health benefit plan developed under section 26.1-36.3-08.

~~5.~~ 6. "Board" means the board of directors of the program established under section 26.1-36.3-07.

~~6. "Carrier" means any entity that provides health insurance in this state. The term includes an insurance company, nonprofit health service organization, fraternal~~

~~benefit society, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.~~

7. "Case characteristics" means demographic or other objective characteristics of a small employer that 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.

8. "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.].

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

~~9.~~ 10. "Committee" means the health benefit plan committee created under section 26.1-36.3-08.

~~10.~~ 11. "Control" is as defined in section 26.1-10-01.

~~11.~~ 12. "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.

~~12.~~ 13. "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.

~~13.~~ 14. "Enrollee" means a person covered under a small employer health benefit plan.

~~14.~~ 15. "Established geographic service area" means a geographic area, as approved by the commissioner of insurance and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

16. "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.

17. "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 as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this Act:

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, 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 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.~~ 18. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract. ~~The term does not include accident only,~~

~~credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.~~

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;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation 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 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.

~~b.~~ f. ~~"Health benefit plan" does not include~~ A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance~~, if the carrier offering that policy or certificate~~ shall comply with the following:

(1) ~~Files~~ File with the commissioner of insurance 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 where premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.

(2) When the policy or certificate is offered for the first time in this state on or after August 1, 1993, files 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.

19. "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.

20. "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.

~~16.~~ 21. "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.

~~17.~~ 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 ~~ninety~~ sixty-three 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.

23. "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.

24. "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.

~~18.~~ 25. "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.

~~19.~~ 26. "Plan of operation" means the plan of operation of the program established under section 26.1-36.3-07.

27. "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.].

~~20.~~ 28. "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.

~~21.~~ 29. "Producer" means insurance agent or insurance broker.

~~22.~~ 30. "Program" means the state small employer carrier reinsurance program created under section 26.1-36.3-07.

~~23.~~ 31. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under ~~one or more~~ any of the following:

~~a. Medicare, medicaid, civilian health and medical program for uniformed services, Indian health services program, or any other similar publicly sponsored program.~~

~~b. A health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.~~

~~c. An individual health insurance policy, including coverage issued by a health maintenance organization, nonprofit health service corporation, and fraternal benefit society that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least one year.~~

a. A group health benefit plan;

b. A health benefit plan;

c. Medicare;

d. Medicaid;

e. Civilian health and medical program for uniformed services;

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

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

h. A health plan offered under 5 U.S.C. 89;

i. A public health plan as defined in federal regulations; and

j. 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)].

The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan" under subsection 18.

~~24.~~ 32. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~25.~~ 33. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.

~~26.~~ 34. "Restricted network provision" means any provision of a health benefit plan that 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.

~~27.~~ 35. "Small employer" means ~~any person that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least three, but no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, must be considered one employer~~, in connection with a group health plan with respect to a calendar and a plan year, an employer who employed an average of at least two but not more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

~~28.~~ 36. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

~~29.~~ 37. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.

SECTION 9. AMENDMENT. Section 26.1-36.3-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-05. Renewability of coverage.

1. A health benefit plan subject to this chapter and section 26.1-36-37.2 must be renewable with respect to all eligible employees and dependents, at the option of the small employer, except for any of the following:

a. ~~Nonpayment of the required premiums.~~ The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments.

b. ~~Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives.~~ The plan sponsor or small employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's minimum participation requirements.

d. Noncompliance with the carrier's employer contribution requirements.

~~e. Repeated misuse of a provider network provision.~~

~~f. The small employer carrier electing to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In that case the carrier shall:~~

~~(1) Provide advance notice of its decision not to renew to the commissioner in each state in which it is licensed; and~~

~~(2) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under this paragraph must be provided at least three working days prior to the notice to the affected small employers.~~

e. A decision by the small employer carrier to discontinue offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the carrier in that market only if the carrier:

(1) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the

commissioner in each state in which an affected insured individual is known to reside at least ninety days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries;

(3) Offers to each plan sponsor provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the carrier to employers in the state; and

(4) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under paragraph 3, the carrier acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

f. A decision by the small employer carrier to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery to small employers in this state. In such a case, the carrier shall:

(1) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provide notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subdivision shall be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries; and

(3) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and not renew coverage under any health benefit plan issued to a small employer.

g. In the case of health benefit plans that are made available in the small employer market only through one or more associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

~~g.~~ h. The commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations. In this case the commissioner shall assist affected small employers in finding replacement coverage.

2. A small employer carrier that elects not to renew a health benefit plan under subdivision f of subsection 1 may not write new business in the small employer market in this state for a period of five years from the date of notice to the commissioner.

3. In the case of a small employer carrier doing business in one established geographic service area of the state, this section only applies to the carrier's operations in that service area.

4. A small employer carrier offering through a network plan may not be required to offer coverage or accept applications pursuant to subsection 1 or 2 in the case of the following:

a. To an eligible person who no longer resides, lives, or works in the service area, or in an area for which the carrier is authorized to do business, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor; or

b. To a small employer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the carrier, or the area for which the carrier is authorized to do business.

5. At the time of coverage renewal, a health insurance carrier may modify the health insurance coverage for a product offered to a group health plan, if for coverage that is available in such market other than only through one or more bona fide

associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

SECTION 10. AMENDMENT. Section 26.1-36.3-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-06. Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers ~~at least two health benefit plans. Each small employer carrier shall offer one~~ all health benefit plans it actively markets to small employers in this state, including a basic health benefit plan and ~~one~~ a standard health benefit plan.

   b. (1) ~~A~~ Subject to subdivision a of subsection 1, a small employer carrier shall issue ~~a basic~~ any health benefit plan ~~or a standard health benefit plan~~ to any eligible small employer that applies for ~~either~~ the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter and section 26.1-36-37.2. However, a carrier may not be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

   (2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 26.1-36.3-03, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans it actively markets to small employers, including at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a ~~basic or standard~~ health benefit plan, are not related to ~~the health status or claim experience~~ a health status-related factor of the small employer, and are applied consistently to all small employers applying

for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

~~c. A small employer is eligible under subdivision b if it employed at least three or more eligible employees within this state on at least fifty percent of its working days during the preceding calendar quarter.~~

~~d. This subsection takes effect one hundred eighty days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to section 26.1-36.3-08; however, if the small employer health reinsurance program created pursuant to section 26.1-36.3-07 is not yet operative on that date, this section becomes effective on the date the program begins operation.~~

2. a. A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed under this subdivision may be used by a small employer carrier beginning sixty days after it is filed unless the commissioner disapproves its use.

b. The commissioner after providing notice and an opportunity for a hearing to the small employer carrier, may disapprove, at any time, the continued use by a small employer carrier of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter and section 26.1-36-37.2.

3. Health benefit plans covering small employers must comply with the following:

a. A health benefit plan may ~~not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan may not define a preexisting condition more restrictively than~~ impose a preexisting condition exclusion only if:

(1) ~~A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or~~ 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) ~~A pregnancy existing on~~ The exclusion extends for a period of not more than twelve months after the effective date of coverage~~.~~;

(3) The exclusion does not relate to pregnancy as a preexisting condition; and

(4) The exclusion does not treat genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

b. A small employer carrier shall ~~waive~~ reduce any time period applicable to a preexisting condition exclusion or limitation period ~~with respect to particular services for the period of time an individual was previously covered~~ by the aggregate of periods the individual was covered by qualifying previous coverage ~~that provided benefits with respect to the services~~, if any, if the qualifying previous coverage was continuous until at least ~~ninety~~ sixty-three days prior to the effective date of the new coverage. ~~The period of continuous coverage may not include a waiting period for the effective date of the new coverage applied by the employer or the carrier~~ 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.

c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion;

however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen 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, shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(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 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.

4. a. A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications under subsection 1 to a small employer if:

(1) ~~A~~ The small employer ~~who applies for coverage is not physically located in the carrier's established geographic service area~~ does not have eligible individuals who live, work, or reside in the service area for such network plan; or

(2) ~~An employee who applies for coverage does not work or reside within the carrier's established geographic service area; or~~ The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier has demonstrated, if required, to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contractholders and enrollees, and that it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

~~(3) Within an area the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that, because of its obligations to existing group policyholders and enrollees, it will not~~

~~have the capacity within its established geographic service area to deliver service adequately to the members of the groups.~~

b. ~~A small employer carrier that cannot offer coverage pursuant to paragraph 3 of subdivision a may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees or to any small employer groups until the later of one hundred eighty days following each refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.~~ A small employer carrier, upon denying health insurance coverage in any service area in accordance with paragraph 2 of subdivision a, may not offer coverage in the small employer market within the service area for a period of one hundred eighty days after the date the coverage is denied.

5. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that ~~requiring the acceptance of small employers in accordance with the provisions of subsection 1 would place the small employer carrier in a financially impaired condition~~ the carrier does not have the financial reserves to underwrite additional coverage and is applying this section uniformly without regard to the claims experience of small employers or any health status-related factor relating to employees and their dependents. A small employer carrier denying coverage in accordance with this section may not offer coverage in connection with a group health benefit plan in the small group market for a period of one hundred eighty days after the health coverage is denied or until the carrier has demonstrated to the commissioner sufficient financial reserves to underwrite financial coverage, whichever is later.

6. This section 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 11. AMENDMENT. Subsection 1 of section 26.1-36.3-11 of the North Dakota Century Code is amended and reenacted as follows:

1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. ~~If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.~~

SECTION 12. 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. "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. "Policy" means any ~~hospital or medical or major medical policy, certificate, or subscriber contract issued on a group or individual basis by an insurer. The term does not include accident only, credit, dental, vision, medicare supplement, long term care, or disability income insurance, coverage issued as a supplement to liability insurance, or automobile medical payment insurance, or a policy or certificate of specified disease, hospital confinement indemnity, limited benefit health insurance, or short term major medical policies with policy terms no longer than twelve months~~ 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 major medical policies offered in the individual market.
3. "Short-term", except as required by the Health Insurance Portability and Accountability Act of 1996, means a policy or plan providing coverage for one hundred eighty-five days or less.

SECTION 13. AMENDMENT. Section 26.1-36.4-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-03. Limits on preexisting ~~conditions provisions~~ condition exclusions. ~~A policy must provide coverage, with respect to a disease or physical condition of a person~~

~~which existed prior to the effective date of the person's coverage under the policy, except for a preexisting disease or physical condition that was diagnosed or treated within the six months immediately prior to the effective date of the person's coverage. The limitation may not apply to loss incurred after the end of the twelve-month period commencing on the effective date of the person's coverage.~~ 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.

SECTION 14. Section 26.1-36.4-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-36.4-03.1. Additional limits on preexisting condition exclusions. A group policy may not impose a preexisting condition exclusion that:

1. Relates to pregnancy as a preexisting condition.
2. Treats genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

SECTION 15. 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 ~~waive~~ reduce any time period applicable to a preexisting condition, for a policy ~~with respect to particular services for the period of time an individual was previously covered~~ by the aggregate of periods the individual was covered by qualifying previous coverage ~~that provided benefits with respect to the services~~, if the qualifying previous coverage as defined in section 26.1-36.3-01 is continuous until at least ~~ninety~~ sixty-three days before the effective date of the new coverage. ~~The period of continuous coverage may not include a waiting period or the effective date of the new coverage applied by the insurer.~~ 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.

SECTION 16. AMENDMENT. Section 26.1-36.4-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-05. Guaranteed renewability of health insurance coverage - Discrimination prohibited.

~~1. An insurer issuing policies under this chapter shall provide for the renewability or continuability of coverage unless:~~

~~a. The individual or group has failed to pay the required premiums.~~

~~b. The individual or group has misrepresented information or committed fraud with respect to coverage of the individual or group.~~

~~c. The group has failed to comply with the insurer's minimum participation requirements.~~

~~d. The insurer has elected to nonrenew all of its policies, other than guaranteed renewable individual policies, in this state. In that case the insurer shall:~~

~~(1) Provide advance notice of its decision not to renew to the commissioner; and~~

~~(2) Provide notice of the decision not to renew coverage to every affected insured and to the commissioner at least one hundred eighty days before the nonrenewal of the policy or contract by the insurer. Notice to the commissioner under this paragraph must be provided at least three business days before notice to an affected insured.~~

~~2. An insurer that elects not to renew a policy as required by this section may not write new business in the individual or group market in this state for a period of five years from the date of notice of its intention not to renew.~~

~~3. The commissioner may allow an insurer to nonrenew a policy if the commissioner finds that continuation of coverage is not in the best interests of policyholders or it would impair the insurer's ability to meet its contractual obligations. The commissioner shall assist the policyholder in finding replacement coverage.~~

1. An insurer issuing policies or certificates under this chapter shall provide for the renewability or continuability of coverage unless:

a. The individual or group has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the insurer has not received timely premium payments.

b. The individual or group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the insurer's minimum group participation requirements.

d. Noncompliance with the insurer's employer group contribution requirements.

e. A decision by the insurer to discontinue offering a particular type of health insurance coverage in the group or individual market. A type of group health benefit plan or individual policy may be discontinued by the insurer in that market only if the insurer:

(1) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage to all affected individuals, employers, participants, beneficiaries, and to the commissioner in each state in which an affected insured is known to reside at least ninety days prior to the nonrenewal of any health benefit plans by the insurer. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected individuals, employers, participants, and beneficiaries;

(3) Offers to each affected group or individual the option to purchase all other health benefit plans or individual coverage currently being offered by the insurer in that market; and

(4) In exercising the option to discontinue the particular type of group health benefit plan or individual coverage and in offering the option of coverage under paragraph 3, the insurer acts uniformly without regard to claims experience or any health status-related factor relating to any affected individuals, participants, or beneficiaries covered or new individuals, participants, or beneficiaries who may become eligible for such coverage.

f. A decision by the insurer to discontinue offering and to nonrenew all its health benefit plans or individual coverage delivered or issued for delivery to employers or individuals in this state. In such a case, the insurer shall:

(1) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;

(2) Provides notice of the decision not to renew coverage to all affected individuals, employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the insurer. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected individuals, employers, participants, and beneficiaries; and

(3) Discontinue all health insurance issued or delivered for issuance in the state's group or individual market and not renew such health coverage in that market.

g. In the case of health benefit plans that are made available in the group or individual market only through one or more associations, the membership of an employer or individual in the association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the insurer's ability to meet its contractual obligations. In this case the commissioner shall assist affected insureds in finding replacement coverage.

2. An insurer that elects not to renew a health benefit plan under subdivision f of subsection 1 may not write new business in the applicable market in this state for a period of five years from the date of notice to the commissioner.

3. In the case of an insurer doing business in one established geographic service area of the state, this section only applies to the insurer's operations in that service area.

4. An insurer offering coverage through a network plan may not be required to offer coverage or accept applications pursuant to subsection 1 or 2 in the case of the following:

   a. To an eligible person who no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor; or

   b. To an insurer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the insurer, or the area for which the insurer is authorized to do business.

5. At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered to a group or individual, if the modification is consistent with state law and effective on a uniform basis.

SECTION 17. REPEAL. Section 26.1-08-05 of the North Dakota Century Code is repealed.

SECTION 18. APPLICATION. Except as required by the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.], this Act applies to:

1. Any health insurance coverage that is offered, sold, issued, or renewed in the individual market after June 30, 1997; and
2. Any group health benefit plan, and health insurance coverage offered in connection with a group health benefit plan, for any plan year beginning after June 30, 1997.

SECTION 19. EFFECTIVE DATE. This Act becomes effective on July 1, 1997.

SECTION 20. EMERGENCY. This Act is declared to be an emergency measure.