Fifty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2120

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to amend and reenact section 26.1-36.3-01 and subsection 2 of section 26.1-36.3-04 of the North Dakota Century Code, relating to the small employer carrier health reinsurance program; and to repeal sections 26.1-36.3-07 and 26.1-36.3-09 of the North Dakota Century Code, relating to the small employer carrier health reinsurance program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

26.1-36.3-01. Definitions. As used in this chapter and section 26.1-36-37.2, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the insurance commissioner, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
2. "Affiliate" or "affiliated" means any entity or 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.

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

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

~~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.~~ 7. "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.~~ 8. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.

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

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

~~12.~~ 11. "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.

~~13.~~ 12. "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.

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

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

~~16.~~ 15. "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.~~ 16. "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 chapter:

a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, 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.

~~18.~~ 17. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract.

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

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

(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.

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

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

(a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance

and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases when 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, file with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

~~19.~~ 18. "Health carrier" or "carrier" means any entity that provides health insurance in this state. For purposes of this chapter, health carrier includes an insurance company, a prepaid limited health service corporation, a fraternal benefit society, a health maintenance organization, nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

~~20.~~ 19. "Health status-related factor" means any of the following factors:

a. Health status;

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

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

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

h. Disability.

~~21.~~ 20. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

~~22.~~ 21. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period

during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:

a. The individual:

(1) Was covered under qualifying previous coverage at the time of the initial enrollment;

(2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and

(3) Requests enrollment within thirty days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

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

~~23.~~ 22. "Medical care" means amounts paid for:

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

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

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

~~24.~~ 23. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid

for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

~~25.~~ 24. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

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

~~27.~~ 25. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~28.~~ 26. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~29.~~ 27. "Producer" means insurance producer.

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

~~31.~~ 28. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under any of the following:

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~~ 17.

~~32.~~ 29. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~33.~~ 30. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.

~~34.~~ 31. "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.

~~35.~~ 32. "Small employer" means, 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.

~~36.~~ 33. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

~~37.~~ 34. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.

SECTION 2. AMENDMENT. Subsection 2 of section 26.1-36.3-04 of the North Dakota Century Code is amended and reenacted as follows:

2. Premium rates for health benefit plans subject to this section and section 26.1-36-37.2 are subject to the following:

a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than fifteen percent.

b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to the employers under the rating

system for that class of business, may not vary from the index rate by more than twenty percent of the index rate.

c. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(2) Any adjustment due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; however, the adjustment may not exceed fifteen percent annually and must be adjusted pro rata for rating periods of less than one year; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

d. Adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents. Premium rates charged for a health benefit plan may not vary by a ratio of greater than four to one after January 1, 1997. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

e. ~~Premium rates for health benefit plans must comply with the requirements of this section notwithstanding any assessment paid or payable by a small employer carrier pursuant to section 26.1-36.3-07.~~

~~f.~~ A small employer carrier may utilize industry as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

~~g.~~ f. In the case of health benefit plans delivered or issued for delivery before August 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions a and b for a period of three years following August 1, 1993. Under this subdivision, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

~~h.~~ g. (1) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(2) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

~~i.~~ h. For the purposes of this subsection, a health benefit plan that uses a restricted provider network may not be considered similar coverage to a health benefit plan that does not use a restricted provider network, if the use of the restricted provider network results in substantial differences in claims costs.

~~j.~~ i. A small employer carrier may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size, without prior approval of the commissioner. Gender may not be used as a case characteristic after January 1, 1996.

~~k.~~ j. The commissioner shall adopt rules to:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(2) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(3) Otherwise implement this section.

SECTION 3. REPEAL. Sections 26.1-36.3-07 and 26.1-36.3-09 of the North Dakota Century Code are repealed.