Life, Annuity and Health Filings – North Dakota Insurance Department
(7/1/08 – 6/30/09)

Total Filings:

	# Filings	Ave. # Days
• Life	951	15
• Annuity	565	26
• Health	928	56
• Total	2,444	33

Filings include:

- Form only
- Rate only
- Form and Rate combined
- Other (primarily advertising)

Life and Annuity filings are primarily Form only filings.

Health filings are divided among:

	# Filings	Ave. # Days
• Form only	280	58
• Rate only	273	45
• Form and Rate combined	151	77
• Other	224	54
• Total	928	56

North Dakota mandated benefits summary

	Mandate	N.D.C.C.	Description
1	Group health policy and medical service contract options for drugs and chiropractic care	26.1-36-06	Requires coverage of all prescribed drugs and medicines and chiropractic care provided by an appropriately licensed chiropractor.
2	Coverage for off-label uses of drugs	26.1-36-06.1	Prohibits carriers from excluding coverage of a drug for a particular indication on the grounds that the drug has not been approved by the FDA for the indication if the drug is recognized for treatment of the indication in one of the standard reference compendia or medical literature.
3	Group health policy and health service contract substance abuse coverage	26.1-36-08	Requires carriers to provide benefits of the same type for other illnesses, for the diagnosis, evaluation and treatment of alcoholism, drug addiction or related illnesses.
4	Group health policy and health service contract mental disorder coverage	26.1-36-09	Requires carriers to provide benefits of the same type offered for other illnesses, for the diagnosis, evaluation and treatment of mental disorders and other related illnesses.
5	Health insurance policy and health service contract—Mammogram examination coverage	26.1-36-09.1	Requires carriers to provide benefits of the same type offered for other illnesses, for: 1. One baseline mammogram examination for each woman who is at least 35 but less than 40 2. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least 40.
6	Health insurance policy and health service contract—Involuntary complications of pregnancy coverage	26.1-36-09.2	Prohibits carriers from applying exclusions, reductions or other limitations to coverage, deductibles or coinsurance provisions for benefits related to involuntary complications of pregnancy, unless they apply generally to all other conditions.
7	Coverage for treatment of certain disorders	26.1-36-09.3	Requires coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage for this condition must be the same as coverage for any other joint disorder.

*Mandates highlighted in gray apply to group policies.

8	Preventive health care—Copayments	26.1-36-09.4	Requires: 1. Coverage for prenatal care benefits. 2. Coverage of recommended immunizations from birth through age five. 3. Coverage for well child visits from birth through age five.
9	Health insurance and health service contract—Prostate-specific antigen test coverage	26.1-36-09.6	Requires carriers to cover an annual digital rectal exam and a prostate-specific antigen test for: (1) an asymptomatic male age 50 and over, (2) a black male age 40 and over, and (3) a male with a family history of prostate cancer age 40 and over.
10	Food and food products for inherited metabolic diseases	26.1-36-09.7	Requires coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease for individuals born after Dec. 31, 1962.
11	Health insurance policy and health service contract—Postdelivery coverage for mothers and newborns	26.1-36-09.8	Requires carriers to provide benefits of the same type offered for illnesses for inpatient care for a mother and her newborn for 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.
12	Dental anesthesia and hospitalization coverage	26.1-36-09.9	Requires carriers to provide benefits for anesthesia and hospitalization for dental care provided to a covered individual who is: (a) under age 9, (b) severely disabled or (c) has a medical condition requiring hospitalization or general anesthesia for dental care treatment.
13	Health insurance policy and health service contract—Prehospital emergency medical services	26.1-36-09.10	Defines "emergency medical condition" as "a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part." Requires that contracts that provide prehospital emergency medical services benefits use the definition above to make coverage decisions.
14	Health insurance coverage for newborn and adopted children—Scope of coverage—Notification of birth or adoption	26.1-36-07	Provides coverage of injury or sickness (including coverage of congenital defects and birth abnormalities) to new children of any insured whose policy includes coverage for a family member. Coverage must be provided from the moment of birth for newly born infants or from the date of physical placement for adopted children.

15	Juvenile's accident and health coverage to continue—Conditions	26.1-36-20	Requires carriers to continue coverage of a juvenile while the legal custody of the juvenile has been given by a court to any public institution or agency, as long as the juvenile meets all other usual qualifications for insurability and continues to pay premiums. It states that incarceration may not be used as a basis for canceling the juvenile's policy.
16	Prisoner's accident and health coverage to continue—Conditions	26.1-36-21	Requires carriers to continue coverage of a prisoner while incarcerated and under state supervision as long as the prisoner meets all other usual qualifications for insurability and continues to pay premiums.
17	Individual and group health insurance for dependents	26.1-36-22	Mandates than an individual or group health insurance policy may be extended to insure the individuals, employees or members with respect to their family members or dependents including dependents of dependents, or any class or classes thereof. The mandate requires that premium for the insurance be paid either from funds contributed by policyholder or from funds contributed by the covered persons (if not the policyholder), or from both. coverage may not be terminated while the child is both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly depebdent on the employee or member for support and maintenance.
18	Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership	26.1-36-23	Requires carriers to offer continued coverage, for up to 39 weeks, of hospital, surgical and major medical benefits to employees or members (and their dependents) whose group coverage would otherwise terminate because of termination of employment or membership.
19	Former spouse's and dependent children's accident and health coverage to continue—Conditions	26.1-36-23.1	Prohibits contracts from including provisions that terminate coverage for a covered spouse solely as a result of a break in the marital relationship except by reason of an entry of a decree of annulment or divorce.
20	Service of advanced registered nurse practitioner—Direct reimbursement required	26.1-36-09.5	Mandates that advanced registered nurse practitioners meeting the state's licensing requirements are entitled to: (1) payment for services performed that are within their scope of practice and (2) direct reimbursement by the insurer.

*Mandates highlighted in gray apply to group policies only.

21	Freedom of choice for pharmacy services	26.1-36-12.2	Prohibits third party payors (including health care insurers) who provide pharmacy services and prescription drugs to any beneficiary from: 1. Preventing beneficiaries from selecting any appropriately licensed pharmacist of his or her choice to provide goods and services; 2. Imposing a copayment fee, or other condition on a beneficiary selecting a participating or contracting provider that is not equally imposed on all beneficiaries; or 3. Denying any appropriately licensed pharmacy or pharmacist willing to accept the terms of the third party payor's contract the right to participate as a preferred provider or as a contracting provider for any policy or plan.
22	Discrimination in optometric services prohibited	43-13-31	Requires that contracts that provide payment for optometric services, make payment regardless of whether the service is performed by a physician or optometrist.
23	Information disclosure	26.2-36-03.1	Requires carriers to make a plan description, written in layperson's terms, including the terms and conditions of coverage available to covered persons.