

**SENATE BILL NO. 2214**

Introduced by

Senators J. Lee, Dever, Warner

Representatives N. Johnson, Kaldor, Weisz

- 1 A BILL for an Act to amend and reenact section 26.1-08-12 of the North Dakota Century Code,  
2 relating to comprehensive health association of North Dakota eligibility provisions.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1. AMENDMENT.** Section 26.1-08-12 of the North Dakota Century Code is  
5 amended and reenacted as follows:

6 **26.1-08-12. Eligibility.**

- 7 1. The association must be open for enrollment by eligible individuals. Eligible  
8 individuals shall apply for enrollment in the association by submitting an application  
9 to the lead carrier. The application must:
- 10 a. ~~Provide the name, address, and age of the applicant.~~  
11 b. ~~Provide the length of applicant's residence in this state.~~  
12 c. ~~Provide the name, address, and age of spouse and children, if any.~~  
13 d. ~~Provide a designation of coverage desired.~~  
14 e. ~~Be~~ be completed fully and accompanied by premium and evidence to prove  
15 eligibility.
- 16 2. Within thirty days of receipt of the application, the lead carrier shall either reject the  
17 application for failing to comply with the requirements of this section or forward the  
18 eligible individual a notice of acceptance and billing information.
- 19 3. At the option of the eligible individual, association coverage is effective:
- 20 a. For an eligible individual applying under subsection 10 or 11, on the signature  
21 date of the application.
- 22 b. For an eligible individual applying under subparagraph a of paragraph 1 of  
23 subdivision a of subsection 5 or under subparagraph a of paragraph 1 of  
24 subdivision c of subsection 5:

- 1                   (1)    On the day following the date shown on the written evidence;
- 2                   (2)    On the signature date of the application, if it is at least one day and less
- 3                   than one hundred eighty days following the date shown on the written
- 4                   evidence; or
- 5                   (3)    On any date after the signature date of the application if the date is at
- 6                   least one day and less than one hundred eighty days following the date
- 7                   shown on the written evidence.
- 8           c.    For an eligible individual applying under subparagraph b or c of paragraph 1
- 9                   of subdivision a of subsection 5 or under subparagraph b or c of paragraph 1
- 10                  of subdivision c of subsection 5:
- 11                  (1)    On the signature date of the application; or
- 12                  (2)    On any date after the signature date of the application but less than one
- 13                  hundred eighty days following the date shown on the written evidence.
- 14           d.    For an eligible individual applying under subdivision b or d of subsection 5:
- 15                  (1)    On the signature date of the application; or
- 16                  (2)    On any date after the signature date of the application, but less than
- 17                  sixty-four days following termination of previous coverage.
- 18           e.    For an eligible individual applying under subsection 6:
- 19                  (1)    On the signature date of the application; or
- 20                  (2)    On any date after the signature date of the application, but less than
- 21                  one hundred eighty days following the date shown on the written
- 22                  evidence from a medical professional.
- 23       4.    An eligible individual may not purchase more than one policy from the association.
- 24       5.    An individual may qualify to enroll in the association for benefit plan coverage as:
- 25           a.    A traditional applicant:
- 26                  (1)    An individual who has been a resident of this state and continues to be
- 27                          a resident of the state who has received from at least one insurance
- 28                          carrier within one hundred eighty days of the date of application, one of
- 29                          the following:
- 30                          (a)    Written evidence of rejection or refusal to issue substantially
- 31                                  similar insurance for health reasons by one insurer.

- 1 (b) Written evidence that a restrictive rider or a preexisting condition  
2 limitation, the effect of which is to reduce substantially, coverage  
3 from that received by an individual considered a standard risk,  
4 has been placed on the individual's policy.
- 5 (c) Written evidence that an insurer has offered to issue comparable  
6 insurance at a rate exceeding the association benefit rate.
- 7 (2) Is not enrolled in health benefits with the state's medical assistance  
8 program.
- 9 b. A Health Insurance Portability and Accountability Act of 1996 applicant:
- 10 (1) An individual who meets the federally defined eligibility guidelines as  
11 follows:
- 12 (a) Has had eighteen months of qualifying previous coverage as  
13 defined in section 26.1-36.3-01, ~~the most recent of which is~~  
14 ~~covered under a group health plan, governmental plan, medicaid,~~  
15 ~~or church plan;~~
- 16 (b) Has applied for coverage under this chapter within sixty-three  
17 days of the termination of the qualifying previous coverage;
- 18 (c) Is not eligible for coverage under medicare or a group health  
19 benefit plan as the term is defined in section 26.1-36.3-01;
- 20 (d) Does not have any other health insurance coverage;
- 21 (e) Has not had the most recent qualifying previous coverage  
22 described in subparagraph a terminated for nonpayment of  
23 premiums or fraud; and
- 24 (f) If offered under the option, has elected continuation coverage  
25 under the federal Consolidated Omnibus Budget Reconciliation  
26 Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state  
27 program, and that coverage has exhausted.
- 28 (2) Is and continues to be a resident of the state.
- 29 (3) Is not enrolled in health benefits with the state's medical assistance  
30 program.
- 31 c. An applicant age sixty-five and over or disabled:

- 1                   (1)    An individual who is eligible for medicare by reason of age or disability
- 2                                   and has been a resident of this state and continues to be a resident of
- 3                                   this state who has received from at least one insurance carrier within
- 4                                   one hundred eighty days of the date of application, one of the following:
- 5                                   (a)    Written evidence of rejection or refusal to issue substantially
- 6                                                                                   similar insurance for health reasons by one insurer.
- 7                                   (b)    Written evidence that a restrictive rider or a preexisting condition
- 8                                                                                   limitation, the effect of which is to reduce substantially, coverage
- 9                                                                                   from that received by an individual considered a standard risk,
- 10                                                                                   has been placed on the individual's policy.
- 11                                   (c)    Written evidence that an insurer has offered to issue comparable
- 12                                                                                   insurance at a rate exceeding the association benefit rate.
- 13                   (2)    Is not enrolled in health benefits with the state's medical assistance
- 14                                   program.
- 15       d.    A Trade Adjustment Assistance Reform Act of 2002 applicant:
- 16                   (1)    A trade adjustment assistance, pension benefit guarantee corporation
- 17                                   individual applicant who:
- 18                                   (a)    Has three or more months of qualifying previous health insurance
- 19                                                                                   coverage at the time of application;
- 20                                   (b)    Has applied for coverage within sixty-three days of the
- 21                                                                                   termination of the individual's previous health insurance
- 22                                                                                   coverage;
- 23                                   (c)    Is and continues to be a resident of the state;
- 24                                   (d)    Is not enrolled in the state's medical assistance program;
- 25                                   (e)    Is not imprisoned under federal, state, or local authority; and
- 26                                   (f)    Does not have health insurance coverage through:
- 27                                                                                   [1]    The applicant's or spouse's employer if the coverage
- 28                                                                                                                                   provides for employer contribution of fifty percent or more
- 29                                                                                                                                   of the cost of coverage of the spouse, the eligible
- 30                                                                                                                                   individual, and the dependents or the coverage is in lieu of
- 31                                                                                                                                   an employer's cash or other benefit under a cafeteria plan.

- 1 [2] A state's children's health insurance program, as defined  
2 under section 50-29-01.
- 3 [3] A government plan.
- 4 [4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071  
5 et seq.] relating to armed forces medical and dental care.
- 6 [5] Part A or part B of title XVIII of the federal Social Security  
7 Act [42 U.S.C. 1395 et seq.] relating to health insurance for  
8 the aged and disabled.
- 9 (2) Coverage under this subdivision may be provided to an individual who  
10 is eligible for health insurance coverage through the federal  
11 Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L.  
12 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer  
13 contribution is less than fifty percent; or the individual marketplace,  
14 including continuation or guaranteed issue, but who elects to obtain  
15 coverage under this subdivision.
- 16 6. The board and lead carrier shall develop a list of medical or health conditions for  
17 which an individual must be eligible for association coverage without applying for  
18 health insurance coverage under subdivisions a and c of subsection 5. Individuals  
19 with written evidence of the existence or history of any medical or health conditions  
20 on the approved list may not be required to provide written evidence of rejection or  
21 refusal, a rate that exceeds the association rates, or substantially reduced  
22 coverage.
- 23 7. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or  
24 reinsurance coverage with respect to an applicant under subdivisions a and c of  
25 subsection ~~4~~ 5 is not sufficient evidence to qualify.
- 26 8. A traditional applicant, as specified under subdivision a of subsection 5, may have  
27 insurance coverage, other than the state's medical assistance program, with an  
28 additional commercial insurer; however, the association will reimburse eligible  
29 claim costs as payer of last resort.
- 30 9. An individual who is eligible for association coverage as specified under  
31 subdivision c of subsection 5 may not have more than one policy that is a

supplement to part A or part B of medicare relating to health insurance for the aged and disabled. The individual may obtain association coverage as a traditional applicant as specified under subdivision a of subsection 5 which is concurrent with a supplement policy offered by a commercial carrier. However, the association will reimburse eligible claims as payer of last resort.

10. ~~Each resident dependent of an individual who is eligible for association coverage~~ If an individual is enrolled in association coverage, that individual's resident dependent is also eligible for association coverage.

11. ~~Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition~~ If an individual is enrolled in association coverage, that individual's resident spouse is also eligible for association coverage.

12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth. This coverage is not available to an applicant under subdivision c of subsection 5.

13. Preexisting conditions.

a. Association coverage must exclude charges or expenses incurred during the first one hundred eighty days following the effective date of coverage for any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the one hundred eighty days immediately preceding the signature date of the application.

b. Association coverage must exclude charges or expenses incurred for maternity during the first two hundred seventy days following the effective date of coverage.

c. Any individual with coverage through the association 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 eighty days of coverage.

- 1 d. A preexisting condition may not be imposed on an individual who is eligible  
2 under subdivision b or d of subsection 5.
- 3 14. Waiting periods do not apply ~~to an individual who:~~
- 4 a. ~~Is receiving~~ To nonelective treatment or procedures for a congenital or  
5 genetic disease.
- 6 b. ~~Has~~ To an individual who has obtained coverage as a federally eligible  
7 individual as defined in subdivision b of subsection 5.
- 8 c. ~~Has~~ To an individual who has obtained coverage as an eligible person under  
9 subdivision a or c of subsection 5, allowing for a reduction in waiting period  
10 days by the aggregate period of qualifying previous coverage in the same  
11 manner as provided in subsection 3 of section 26.1-36.3-06 and provided the  
12 association application is made within sixty-three days of termination of the  
13 qualifying previous coverage.
- 14 d. ~~Has~~ To an individual who has obtained coverage as an eligible individual  
15 under subdivision d of subsection 5.
- 16 15. An individual is not eligible for coverage through the association if:
- 17 a. The individual is enrolled in health benefits with the state's medical assistance  
18 program.
- 19 b. The individual has previously terminated association coverage unless twelve  
20 months have lapsed since such termination. This limitation does not apply to  
21 an applicant who is a federally defined eligible individual as defined under  
22 subdivision b of subsection 5.
- 23 c. The association has paid out one million dollars in benefits on behalf of the  
24 individual.
- 25 d. The individual is imprisoned under federal, state, or local authority. This  
26 limitation does not apply to an applicant who is a federally defined eligible  
27 individual as defined under subdivision b of subsection 5.
- 28 e. The individual's premiums are paid for or reimbursed under any  
29 government-sponsored program, government agency, health care provider,  
30 nonprofit charitable organization, or the individual's employer. However, this  
31 subdivision does not apply if the individual's premiums are paid for or

- 1                               reimbursed under a program established under the federal Trade Adjustment  
2                               Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933].
- 3           16.   A period of creditable coverage is not counted with respect to the enrollment of an  
4                               individual who seeks coverage under this chapter if after such period and before  
5                               the enrollment date, the individual experiences a significant break in coverage  
6                               which is more than sixty-three days.