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Sixty-fourth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2231

Introduced by

Senator J. Lee

Representative Weisz

A BILL for an Act to amend and reenact section 26.1-08-06 of the North Dakota Century Code, relating to the comprehensive health association; to provide a contingent effective date; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06. Comprehensive benefit plan.

1. The benefit plan must offer comprehensive health care coverage to every eligible individual. The coverage to be issued by the association, its schedule of benefits, exclusions, and other limitations must be established by the lead carrier and subject to the approval of the board.
2. In establishing the benefit plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate. Benefit levels, deductibles, coinsurance factors, copayments, exclusions, and limitations may be applied as determined to be generally reflective of health insurance coverage provided in the state, but may be maintained at a level that will allow the benefit plan to qualify as minimum essential coverage under the provisions and rules of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148].
3. The coverage may include deductibles of not less than five hundred dollars per individual per benefit period.
4. The coverage must include a limitation of not less than three thousand dollars per individual on the total annual out-of-pocket expenses for services covered under this section.

5. Any coverage or combination of coverages through the association may not exceed a lifetime maximum benefit of one million dollars for an individual.
6. The coverage may include cost-containment measures and requirements, including preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost-effective.
7. The coverage may include preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.
8. Coverage must include 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.
9. Coverage must include substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.
10. Covered expenses must include, at the option of the eligible individual, professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.
11. The coverage must include organ transplants as approved by the board.
12. The association must be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under an association benefit plan must be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workforce safety and insurance coverage, automobile medical payment or liability insurance whether provided on the basis of fault or no fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. The association must have a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.
13. The board may modify the benefit plan coverage for the purpose of enabling the plan coverage, design, and operation to qualify as minimum essential coverage under the

provisions and rules of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148].

SECTION 2. CONTINGENT EFFECTIVE DATE. This Act becomes effective on the date the insurance commissioner certifies to the secretary of state and the legislative council that the United States department of health and human services does not provide a minimum essential coverage designation to state high-risk pools which qualifies the state high-risk pool as minimum essential coverage under the provisions and rules of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148].

SECTION 3. EXPIRATION DATE. This Act is effective through July 31, 2017, and after that date is ineffective.