Sixty-seventh
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

Senator Mathern

A BILL for an Act to create and enact chapter 26.1-36.8 of the North Dakota Century Code, relating to requirements of health insurance policies; to provide for application; and to provide a contingent effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.8 of the North Dakota Century Code is created and enacted as follows:

26.1-36.8-01. Definitions.

As used in this chapter:

1. "Affiliation period" means a period that begins on a policyholder or dependent's enrollment date, runs concurrently with any waiting period under the health insurance policy, must expire before coverage is effective, and during which the policy provider need not provide benefits for medical care and may not charge any premium to the policyholder or dependent.
2. "Commissioner" means the commissioner of insurance.
3. "Cost-sharing" means any copayment, coinsurance, or deductible required by, or on behalf of, a covered individual in order to receive a specific health care item or service covered by a health insurance policy.
4. "Drug" has the same meaning as provided under section 19-02.1-01.
5. "Health insurance policy" means any individual insurance policy, group insurance policy, or other health benefit plan subject to the requirements of chapter 26.1-36.
6. "Pharmacy benefits manager" has the same meaning as provided under section 19-03.6-01.
7. "Pre-existing condition exclusion" means a limitation or exclusion of benefits related to a condition based on the fact the condition was present before the enrollment date for

coverage, regardless of whether any medical diagnosis, care, or treatment was recommended or received before the enrollment date.

8. "Premium adjustment percentage" for any calendar year means the percentage by which the average per capita premium for health insurance policies in this state in the previous calendar year, as determined by the commissioner not later than October first of such preceding calendar year, exceeds such average per capita premium for 2020.

26.1-36.8-02. Required policy provisions - Rules.

1. The commissioner shall adopt rules that set minimum policy coverage standards applicable to a health insurance policy subject to this chapter. In addition to other requirements provided by law, the standards must require a policy regulated under this chapter to provide as benefits to all enrollees coverage for:
   a. Ambulatory patient services;
   b. Emergency services;
   c. Hospitalization;
   d. Maternity and newborn care;
   e. Mental health and substance use disorder services, including behavioral health treatment;
   f. Drugs;
   g. Rehabilitative and habilitative services and devices;
   h. Laboratory services;
   i. Preventative and wellness services and chronic disease management; and
   j. Pediatric services, including oral and vision care.
2. A health insurance policy subject to this chapter may not establish lifetime or annual limits on the dollar value of benefits described in subsection 1 for any covered individual.
3. A health insurance policy subject to this chapter which offers coverage for a child or stepchild of a policyholder must continue to offer such coverage, at the option of the policyholder, until the unmarried child or stepchild reaches the age of twenty-six.

26.1-36.8-03. Limitations on pre-existing condition exclusions for health insurance policies.

1. A health insurance policy issuer may not impose a pre-existing condition exclusion and may not deny enrollment to a individual on the basis of a pre-existing condition.
2. A health insurance policy issuer may:
   a. Restrict enrollment in a health insurance policy to open enrollment and special enrollment periods in accordance with other provisions of this chapter.
   b. Impose an affiliation period on any health insurance policy that is not provided through the individual market. An affiliation period may not exceed ninety days and may not apply to emergency services.
   c. Use other alternatives approved by the commissioner to address adverse selection.

26.1-36.8-04. Fairness in cost-sharing and ratemaking - Rules.

1. A health insurance policy issuer may not require cost-sharing in an amount greater than the cost-sharing limit amount.
   a. For plan years beginning in calendar year 2021, the cost-sharing limit amount is eight thousand one hundred fifty dollars for self-only coverage and sixteen thousand three hundred dollars for other than self-only coverage.
   b. For plan years beginning after calendar year 2021, the cost-sharing limit is equal to the dollar amount applicable to the previous calendar year, increased by the product of that amount and the premium adjustment percentage as determined by the commissioner for the calendar year.
2. In calculating an insured's contribution to an applicable cost-sharing requirement, including the annual limitation on cost-sharing subject to subsection 1:
   a. An insurer shall include any cost-sharing amounts paid by the insured or on behalf of an enrollee by another person; and
   b. A pharmacy benefits manager shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person.
3. Premium rates charged for any health insurance policy subject to this chapter must be reasonable in relation to the benefits available under the policy, as determined by the commissioner.

4. A health insurance policy subject to this chapter may charge different premium rates for each individual covered by that policy; however, the premium rates may vary only in relation to:
   a. Whether the policy covers an individual or a family;
   b. Rating area, as established pursuant to subsection 6;
   c. Age, except that such rate may not vary by more than three to one for adults; and
   d. Tobacco use, except that such rate may not vary by more than one and one-half to one.
5. With respect to family coverage under an individual or group health insurance policy, the rating variations permitted under this section must be applied based on the portion of the premium attributable to each family member covered under the policy.
6. The commissioner shall adopt rules to establish:
   a. One or more geographic rating areas within the state and the permissible age bands within which premium rates may vary; and
   b. Minimum standards for ratemaking and cost-sharing, in accordance with accepted actuarial principles and practices.

26.1-36.8-05. Rules - Application.

1. The commissioner shall adopt rules addressing any standard or practice necessary to effectuate the purposes of this chapter.
2. Unless a rule provides a different application date, a rule adopted under this chapter applies beginning six months after the date the rule becomes final.

26.1-36.8-06. Conflict of laws.

1. A health insurance policy subject to this chapter remains subject to every other requirement and provision of this title which is not inconsistent with this chapter.
2. If a provision of this chapter conflicts with another provision of this title, the provision of this chapter controls, unless the application of this chapter would result in a reduction of coverage.

SECTION 2. APPLICATION. This Act applies to a health insurance policy delivered, executed, issued, amended, adjusted, or renewed in this state on or after six months following finalization of the rules adopted under chapter 26.1-36.8. This chapter does not abridge or

otherwise affect a health insurance policy already in effect at the time this chapter becomes applicable until that policy is renewed, amended, or adjusted.

SECTION 3. CONTINGENT EFFECTIVE DATE. This Act becomes effective three months after the insurance commissioner certifies to the legislative council that a court of competent jurisdiction has ruled all or a significant portion of the federal Patient Protection and Affordable Care Act is unconstitutional and the judgment of that court has become final and definitive.