

Introduced by

Legislative Management

(Health Care Committee)

1 A BILL for an Act to create and enact sections 26.1-36.4-03.2 and 26.1-36.4-03.3 of the North
2 Dakota Century Code, relating to hospital and medical insurance pre-existing conditions and
3 guaranteed issue; and to amend and reenact section 26.1-36.3-01, subsection 2 of section
4 26.1-36.3-06, and sections 26.1-36.4-02 and 26.1-36.4-04 of the North Dakota Century Code,
5 relating to small employer employee health insurance and hospital and medical insurance
6 guaranteed issue and guaranteed availability.

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

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

10 **26.1-36.3-01. Definitions.**

11 As used in this chapter and section 26.1-36-37.2, unless the context otherwise requires:

- 12 1. "Actuarial certification" means a written statement by a member of the American
13 academy of actuaries, or other individual acceptable to the insurance commissioner,
14 that a small employer carrier is in compliance with section 26.1-36.3-04, based upon
15 the person's examination of the small employer carrier, including a review of the
16 appropriate records and the actuarial assumptions and methods used by the small
17 employer carrier in establishing premium rates for applicable health benefit plans.
- 18 2. "Affiliate" or "affiliated" means ~~any entity or a~~ person ~~who~~that directly or indirectly
19 through one or more intermediaries, controls or is controlled by, or is under common
20 control with, a specified ~~entity or~~ person.
- 21 3. "Association" means, with respect to health insurance coverage offered in this state,
22 an association that:
- 23 a. Has been actively in existence for at least five years;

- 1 b. Has been formed and maintained in good faith for purposes other than obtaining
2 insurance;
- 3 c. Does not condition membership in the association on any health status-related
4 factor relating to an individual, including an employee or dependent of an
5 employee;
- 6 d. Makes health insurance coverage offered through the association available to all
7 members regardless of any health status-related factor relating to the members,
8 or individuals eligible for coverage through a member; and
- 9 e. Does not make health insurance coverage offered through the association
10 available other than in connection with a member of the association.
- 11 4. "Base premium rate" means, for each class of business as to a rating period, the
12 lowest premium rate charged or that could have been charged under the rating system
13 for that class of business by the small employer carrier to small employers with similar
14 case characteristics for health benefit plans with the same or similar coverage.
- 15 5. "Case characteristics" means demographic or other objective characteristics of a small
16 employer ~~that~~which are considered by the small employer carrier in the determination
17 of premium rates for the small employer; however, claim experience, health status,
18 and duration of coverage are not case characteristics.
- 19 6. "Church plan" has the meaning given the term under section 3(33) of the Employee
20 Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001
21 et seq.].
- 22 7. "Class of business" means all or a separate grouping of small employers established
23 under section 26.1-36.3-03.
- 24 8. "Control" ~~is as defined in~~has the same meaning as provided under section 26.1-10-01.
- 25 9. "Dependent" means a spouse; an unmarried child, including a dependent of an
26 unmarried child, under the age of twenty-two; an unmarried child who is a full-time
27 student under the age of twenty-six and who is financially dependent upon the
28 enrollee; and an unmarried child, including a dependent of an unmarried child, of any
29 age who is medically certified as disabled and dependent upon the enrollee as set
30 forth in section 26.1-36-22.

- 1 10. "Eligible employee" means an employee who works on a full-time basis and has a
2 normal workweek of thirty or more hours. The term includes a sole proprietor, a
3 partner of a partnership, and an independent contractor, if the sole proprietor, partner,
4 or independent contractor is included as an employee under a health benefit plan of a
5 small employer. The term does not include an employee who works on a part-time,
6 temporary, or substitute basis.
- 7 11. "Enrollee" means ~~a person~~ an individual covered under a small employer health benefit
8 plan.
- 9 12. "Established geographic service area" means a geographic area, as approved by the
10 insurance commissioner and based on the carrier's certificate of authority to transact
11 insurance in this state, within which the carrier is authorized to provide coverage.
- 12 13. "Governmental plan" means an employee welfare benefit plan as defined in
13 section 3(32) of the Employee Retirement Income Security Act of 1974
14 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.
- 15 14. "Group health benefit plan" means an employee welfare benefit plan as defined in
16 section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406;
17 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent ~~that~~ the plan provides medical care
18 as defined in this section and including items and services paid for as medical care to
19 employees or ~~their~~ dependents of the employees as defined under the terms of the
20 plan directly or through insurance, reimbursement, or otherwise. For purposes of this
21 chapter:
- 22 a. A plan, fund, or program that would not be, but for this section, an employee
23 welfare benefit plan and which is established or maintained by a partnership, to
24 the extent ~~that~~ the plan, fund, or program provides medical care, including items
25 and services paid for as medical care, to present or former partners in the
26 partnership, or to ~~their~~ dependents of the present or former partners, as defined
27 under the terms of the plan, fund, or program, directly or through insurance,
28 reimbursement, or otherwise, must be treated as an employee welfare benefit
29 plan ~~which~~ that is a group health benefit plan;
- 30 b. In the case of a group health benefit plan, the term "employer" also includes the
31 partnership in relationship to any partner; and

- 1 c. In the case of a group health benefit plan, the term "participant" also includes:
- 2 (1) In connection with a group health benefit plan maintained by a partnership,
- 3 an individual who is a partner in relation to the partnership; or
- 4 (2) In connection with a group health benefit plan maintained by a
- 5 self-employed individual, under which one or more employees are
- 6 participants, the self-employed individual, if the individual is, or may
- 7 become, eligible to receive benefits under the plan or the beneficiaries may
- 8 be eligible to receive any benefit.
- 9 15. "Guaranteed availability" means a health plan is guaranteed to be available to an
- 10 applicant regardless of health status, age, or income.
- 11 16. "Guaranteed issue" means a health plan is guaranteed to be issued to an applicant
- 12 regardless of health status, age, or income.
- 13 17. a. "Health benefit plan" means any hospital or medical or major medical policy,
- 14 certificate, or subscriber contract.
- 15 b. "Health benefit plan" does not include one or more, or any combination of, the
- 16 following:
- 17 (1) Coverage only for accident; or disability income insurance, or any
- 18 combination thereof accident and disability income insurance;
- 19 (2) Coverage issued as a supplement to liability insurance;
- 20 (3) Liability insurance, including general liability insurance and automobile
- 21 liability insurance;
- 22 (4) Workforce safety and insurance or similar insurance;
- 23 (5) Automobile medical payment insurance;
- 24 (6) Credit-only insurance;
- 25 (7) Coverage for onsite medical clinics; and
- 26 (8) Other similar insurance coverage, specified in federal regulations, under
- 27 which benefits for medical care are secondary or incidental to other
- 28 insurance.
- 29 c. "Health benefit plan" does not include the following benefits if ~~they~~ the benefits
- 30 are provided under a separate policy, certificate, or contract of insurance or are
- 31 otherwise not an integral part of the plan:

- 1 (1) Limited scope dental or vision benefits;
- 2 (2) Benefits for long-term care, nursing home care, home health care,
- 3 community-based care, or any combination thereof; or
- 4 (3) Such other similar, limited benefits as are specified in federal regulations.
- 5 d. "Health benefit plan" does not include the following benefits if the benefits are
- 6 provided under a separate policy, certificate, or contract of insurance, there is no
- 7 coordination between the provision of the benefits, and any exclusion of benefits
- 8 under any group health benefit plan maintained by the same plan sponsor, and
- 9 the benefits are paid with respect to an event without regard to whether benefits
- 10 are provided with respect to such an event under any group health plan
- 11 maintained by the same plan sponsor:
- 12 (1) Coverage only for specified disease or illness; or
- 13 (2) Hospital indemnity or other fixed indemnity insurance.
- 14 e. "Health benefit plan" does not include the following if offered as a separate policy,
- 15 certificate, or contract of insurance:
- 16 (1) Medicare supplemental health insurance as defined under section 1882(g)
- 17 (1) of the Social Security Act;
- 18 (2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and
- 19 (3) Similar supplemental coverage provided under a group health plan.
- 20 f. A carrier offering a policy or certificate of specified disease, hospital confinement
- 21 indemnity, or limited benefit health insurance shall comply with the following:
- 22 (1) File with the insurance commissioner on or before March first of each year a
- 23 certification that contains:
- 24 (a) A statement from the carrier certifying that the policy or certificate is
- 25 being offered and marketed as supplemental health insurance and not
- 26 as a substitute for hospital or medical expense insurance or major
- 27 medical expense insurance.
- 28 (b) A summary description of the policy or certificate, including the
- 29 average annual premium rates, or range of premium rates in cases
- 30 when if premiums vary by age, gender, or other factors, charged for
- 31 the policy and certificate in this state.

1 (2) ~~When~~If the policy or certificate is offered for the first time in this state on or
2 after August 1, 1993, file with the commissioner the information and
3 statement required in paragraph 1 at least thirty days before the date the
4 policy or certificate is issued or delivered in this state.

5 ~~16-18.~~ "Health carrier" or "carrier" means any entity that provides health insurance in this
6 state. For purposes of this chapter, health carrier includes an insurance company, a
7 prepaid limited health service corporation, a fraternal benefit society, a health
8 maintenance organization, nonprofit health service corporation, and any other entity
9 providing a plan of health insurance or health benefits subject to state insurance
10 regulation.

11 ~~17-19.~~ "Health status-related factor" means any of the following factors:

- 12 a. Health status;
- 13 b. Medical condition, including both physical and mental illness;
- 14 c. Claims experience;
- 15 d. Receipt of health care;
- 16 e. Medical history;
- 17 f. Genetic information;
- 18 g. Evidence of insurability, including condition arising out of acts of domestic
19 violence; or
- 20 h. Disability.

21 ~~18-20.~~ "Index rate" means, for each class of business as to a rating period for small
22 employers with similar case characteristics, the arithmetic average of the applicable
23 base premium rate and the corresponding highest premium rate.

24 ~~19-21.~~ "Late enrollee" means an eligible employee or dependent who requests enrollment in
25 a health benefit plan of a small employer following the initial enrollment period during
26 which the individual is entitled to enroll under the terms of the health benefit plan,
27 provided ~~that~~ the initial enrollment period is a period of at least thirty days. An eligible
28 employee or dependent may not be considered a late enrollee, however, if:

- 29 a. The individual:

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

- 1 (2) Lost coverage under qualifying previous coverage as a result of termination
2 of employment or eligibility, the involuntary termination of the qualifying
3 previous coverage, death of a spouse, or divorce; and
- 4 (3) Requests enrollment within thirty days after termination of the qualifying
5 previous coverage.
- 6 b. The individual is employed by an employer that offers multiple health benefit
7 plans and the individual elects a different plan during an open enrollment period.
- 8 c. A court has ordered coverage be provided for a spouse or minor or dependent
9 child under a covered employee's health benefit plan and request for enrollment
10 is made within thirty days after issuance of the court order.
- 11 d. The individual had coverage under a Consolidated Omnibus Budget
12 Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the
13 coverage under that provision was exhausted.
- 14 ~~20-22.~~ "Medical care" means amounts paid for:
- 15 a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts
16 paid for the purpose of affecting any structure or function of the body;
- 17 b. Transportation primarily for and essential to medical care referred to in
18 subdivision a; and
- 19 c. Insurance covering medical care referred to in subdivisions a and b.
- 20 ~~24-23.~~ "Network plan" means health insurance coverage offered by a health carrier under
21 which the financing and delivery of medical care, including items and services paid for
22 as medical care, are provided, in whole or in part, through a defined set of providers
23 under contract with the carrier.
- 24 ~~22-24.~~ "New business premium rate" means, for each class of business as to a rating period,
25 the lowest premium rate charged or offered, or which could have been charged or
26 offered, by the small employer carrier to small employers with similar case
27 characteristics for newly issued health benefit plans with the same or similar coverage.
- 28 ~~23-25.~~ "Plan sponsor" has the meaning given the term under section 3(16)(B) of the
29 Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829;
30 29 U.S.C. 1001 et seq.].

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- 1 ~~24-26.~~ "Premium" means money paid by a small employer and eligible employees as a
2 condition of receiving coverage from a small employer carrier, including any fees or
3 other contributions associated with the health benefit plan.
- 4 ~~25-27.~~ "Producer" means insurance producer.
- 5 ~~26-28.~~ a. "Qualifying previous coverage" and "qualifying existing coverage" mean, with
6 respect to an individual, health benefits or coverage provided under any of the
7 following:
- 8 a. (1) A group health benefit plan;
- 9 b. (2) A health benefit plan;
- 10 c. (3) Medicare;
- 11 d. (4) Medicaid;
- 12 e. (5) Civilian health and medical program for uniformed services;
- 13 f. (6) A medical care program of the Indian health service or of a tribal
14 organization;
- 15 g. (7) A state health benefit risk pool, including coverage issued under chapter
16 26.1-08;
- 17 h. (8) A health plan offered under 5 U.S.C. 89;
- 18 i. (9) A public health plan as defined in federal regulations, including a plan
19 maintained by a state government, the United States government, or a
20 foreign government;
- 21 j. (10) A health benefit plan under section 5(e) of the Peace Corps Act
22 [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and
- 23 k. (11) A state's children's health insurance program funded through title XXI of the
24 federal Social Security Act [42 U.S.C. 1397aa et seq.].
- 25 b. The term "qualifying previous coverage" does not include coverage of benefits
26 excepted from the definition of a "health benefit plan".
- 27 ~~27-29.~~ "Rating period" means the calendar period for which premium rates established by a
28 small employer carrier are assumed to be in effect.
- 29 ~~28-30.~~ "Reinsuring carrier" means a small employer carrier ~~which~~that reinsures individuals or
30 groups with the program.

1 ~~29-31.~~ "Restricted network provision" means any provision of a health benefit plan ~~that~~which
2 conditions the payment of benefits, in whole or in part, on the use of health care
3 providers that have entered ~~into~~ a contractual arrangement with the carrier under
4 chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered
5 individuals.

6 ~~30-32.~~ "Small employer" means, in connection with a group health plan with respect to a
7 calendar and a plan year, an employer ~~whethat~~that employed an average of at least two
8 but not more than fifty eligible employees on business days during the preceding
9 calendar year and ~~whewhich~~which employs at least two employees on the first day of the
10 plan year.

11 ~~31-33.~~ "Small employer carrier" means any carrier that offers health benefit plans covering
12 eligible employees of one or more small employers in this state.

13 **SECTION 2. AMENDMENT.** Subsection 2 of section 26.1-36.3-06 of the North Dakota
14 Century Code is amended and reenacted as follows:

- 15 2. Health benefit plans covering small employers must comply with the following:
- 16 a. A health benefit plan may impose a pre-existing condition exclusion only if:
- 17 (1) The exclusion relates to a condition, regardless of the cause of the
18 condition, for which medical advice, diagnosis, care, or treatment was
19 recommended or received within the six-month period immediately
20 preceding the effective date of coverage;
- 21 (2) The exclusion extends for a period of not more than ~~twelvesix~~six months after
22 the effective date of coverage;
- 23 (3) The exclusion does not relate to pregnancy as a pre-existing condition; and
24 (4) The exclusion does not treat genetic information as a pre-existing condition
25 in the absence of a diagnosis of a condition related to such information.
- 26 b. A small employer carrier shall reduce any time period applicable to a pre-existing
27 condition exclusion or limitation period by the aggregate of periods the individual
28 was covered by qualifying previous coverage, if any, if the qualifying previous
29 coverage was continuous until at least ~~sixty-three~~ninety days ~~prior to~~before the
30 effective date of the new coverage. Any waiting period applicable to an individual
31 for coverage under a group health benefit plan may not be taken into account in

1 determining the period of continuous coverage. This subdivision does not
2 preclude application of an employer waiting period applicable to all new enrollees
3 under the health benefit plan. Small employer carriers shall credit coverage by
4 either a standard method or an alternative method. The commissioner shall adopt
5 rules for crediting coverage under the standard and alternative method. These
6 rules must be consistent with the Health Insurance Portability and Accountability
7 Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any
8 federal rules adopted pursuant thereto to the federal Act.

9 c. A health benefit plan may exclude coverage for late enrollees for ~~the greater of~~
10 ~~eighteen months or for an eighteen-month pre-existing condition exclusion~~ up to
11 six months; however, if both a period of exclusion from coverage and a pre-
12 existing condition exclusion are applicable to a late enrollee, the combined period
13 may not exceed ~~eighteen~~ six months from the date the individual enrolls for
14 coverage under the health benefit plan.

15 d. (1) Except as provided in this subdivision, a small employer carrier shall apply
16 requirements used to determine whether to provide coverage to a small
17 employer, including requirements for minimum participation of eligible
18 employees and minimum employer contributions, uniformly among all small
19 employers with the same number of eligible employees who are applying for
20 coverage or receiving coverage from the small employer carrier.

21 (2) A small employer carrier may vary application of minimum participation
22 requirements and minimum employer contribution requirements only by the
23 size of the small employer group.

24 (3) (a) Except as provided in subparagraph b, a small employer carrier, in
25 applying minimum participation requirements with respect to a small
26 employer, may not consider employees or dependents who have
27 qualifying existing coverage in determining whether the applicable
28 percentage of participation is met. For purposes of determining the
29 applicable percentage of participation under this subparagraph only,
30 individual health benefit plans are not included in the definition of
31 "qualifying existing coverage" under section 26.1-36.3-01.

- 1 (b) With respect to a small employer, with ten or fewer eligible
2 employees, a small employer carrier may consider employees or
3 dependents who have coverage under another health benefit plan
4 sponsored by the small employer in applying minimum participation
5 requirements.
- 6 (4) A small employer carrier may not increase any requirement for minimum
7 employee participation or any requirement for minimum employer
8 contribution applicable to a small employer at any time after the small
9 employer has been accepted for coverage.
- 10 e. (1) If a small employer carrier offers coverage to a small employer, the small
11 employer carrier shall offer coverage to all of the eligible employees of a
12 small employer and their dependents. A small employer carrier may not offer
13 coverage only to certain individuals in a small employer group or only to part
14 of the group, except in the case of late enrollees as provided in
15 subdivision c.
- 16 (2) Except as permitted under subsection 1 and this subsection, a small
17 employer carrier may not modify a health benefit plan with respect to a small
18 employer or any eligible employee or dependent through riders,
19 endorsements, or otherwise, to restrict or exclude coverage for certain
20 diseases or medical conditions otherwise covered by the health benefit plan.

21 **SECTION 3. AMENDMENT.** Section 26.1-36.4-02 of the North Dakota Century Code is
22 amended and reenacted as follows:

23 **26.1-36.4-02. Definitions.**

24 As used in this chapter, the definitions in section 26.1-36.3-01 apply, unless the context
25 otherwise requires. In addition:

- 26 1. "Guaranteed issue" means an individual health plan is guaranteed to be issued to an
27 applicant regardless of health status, age, or income.
- 28 2. "Individual health plan" has the same meaning as provided under section
29 26.1-36-02.2.

1 3. "Insurer" means any insurance company, nonprofit health service organization,
2 fraternal benefit society, or health maintenance organization that provides a plan of
3 health insurance or health benefits subject to state insurance regulation.

4 ~~2.4.~~ "Policy" means any health benefit plan as defined in section 26.1-36.3-01, whether
5 offered on a group or individual basis. The term does not include short-term
6 limited-duration health insurance plans offered in the individual market.

7 ~~3.5.~~ "Short-term limited-duration health insurance plan", except as required by the Health
8 Insurance Portability and Accountability Act of 1996, is defined by section 26.1-36-49.

9 **SECTION 4.** Section 26.1-36.4-03.2 of the North Dakota Century Code is created and
10 enacted as follows:

11 **26.1-36.4-03.2. Individual health plans - Pre-existing conditions - Limitations.**

12 An insurer may not impose a pre-existing condition exclusion on an individual health plan
13 unless:

14 1. The exclusion relates to a condition, regardless of the cause of the condition, for which
15 medical diagnosis, care, or treatment was recommended or received within the six-
16 month period ending on the effective date of the insured's coverage; and

17 2. The exclusion extends for not more than six months after the effective date of
18 coverage.

19 **SECTION 5.** Section 26.1-36.4-03.3 of the North Dakota Century Code is created and
20 enacted as follows:

21 **26.1-36.4-03.3. Individual health plans - Guaranteed issue.**

22 If an insurer offers an individual health plan, the insurer shall offer all the insurer's individual
23 health plans to all applicants as guaranteed issue.

24 **SECTION 6. AMENDMENT.** Section 26.1-36.4-04 of the North Dakota Century Code is
25 amended and reenacted as follows:

26 **26.1-36.4-04. Portability of insurance policies.**

27 An insurer shall reduce any time period applicable to a pre-existing condition, for a policy by
28 the aggregate of periods the individual was covered by qualifying previous coverage, if the
29 qualifying previous coverage as defined in section 26.1-36.3-01 is continuous until at least
30 ~~sixty-three~~ninety days before the effective date of the new coverage. Any waiting period
31 applicable to an individual for coverage under a health benefit plan may not be taken into

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- 1 account in determining the period of continuous coverage. Insurers shall credit coverage in the
- 2 same manner as provided by section 26.1-36.3-06 and the rules adopted by the commissioner
- 3 ~~pursuant thereto~~under that section.