CHAPTER 26.1-36.3
SMALL EMPLOYER EMPLOYEE HEALTH INSURANCE

26.1-36.3-01. (Effective through December 31, 2013) Definitions.

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

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the insurance commissioner, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
3. "Association" means, with respect to health insurance coverage offered in this state, an association that:
   a. Has been actively in existence for at least five years;
   b. Has been formed and maintained in good faith for purposes other than obtaining insurance;
   c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee or dependent of an employee;
   d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member; and
   e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.
4. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.
5. "Basic health benefit plan" means a lower cost health benefit plan developed under section 26.1-36.3-08.
6. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.
7. "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].
8. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.
9. "Committee" means the health benefit plan committee created under section 26.1-36.3-08.
10. "Control" is as defined in section 26.1-10-01.
11. "Dependent" means a spouse, an unmarried child, including a dependent of an unmarried child, under the age of twenty-two, an unmarried child who is a full-time student under the age of twenty-six and who is financially dependent upon the enrollee, and an unmarried child, including a dependent of an unmarried child, of any age who is medically certified as disabled and dependent upon the enrollee as set forth in section 26.1-36-22.
12. "Eligible employee" means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a

small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

13. "Enrollee" means a person covered under a small employer health benefit plan.
14. "Established geographic service area" means a geographic area, as approved by the insurance commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
15. "Governmental plan" means an employee welfare benefit plan as defined in section 3(32) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.
16. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this chapter:
    a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, must be treated as an employee welfare benefit plan which is a group health benefit plan;
    b. In the case of a group health benefit plan, the term "employer" also includes the partnership in relationship to any partner; and
    c. In the case of a group health benefit plan, the term "participant" also includes:
        (1) In connection with a group health benefit plan maintained by a partnership, an individual who is a partner in relation to the partnership; or
        (2) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive benefits under the plan or the beneficiaries may be eligible to receive any benefit.
17. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract.
    b. "Health benefit plan" does not include one or more, or any combination of, the following:
        (1) Coverage only for accident, or disability income insurance, or any combination thereof;
        (2) Coverage issued as a supplement to liability insurance;
        (3) Liability insurance, including general liability insurance and automobile liability insurance;
        (4) Workforce safety and insurance or similar insurance;
        (5) Automobile medical payment insurance;
        (6) Credit-only insurance;
        (7) Coverage for onsite medical clinics; and
        (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance.
    c. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
        (1) Limited scope dental or vision benefits;
        (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
        (3) Such other similar, limited benefits as are specified in federal regulations.

d. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits, and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
   (1) Coverage only for specified disease or illness; or
   (2) Hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:
   (1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
   (2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and
   (3) Similar supplemental coverage provided under a group health plan.

f. A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance shall comply with the following:
   (1) File with the insurance commissioner on or before March first of each year a certification that contains:
      (a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.
      (b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases when premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.
   (2) When the policy or certificate is offered for the first time in this state on or after August 1, 1993, file with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

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

19. "Health status-related factor" means any of the following factors:
   a. Health status;
   b. Medical condition, including both physical and mental illness;
   c. Claims experience;
   d. Receipt of health care;
   e. Medical history;
   f. Genetic information;
   g. Evidence of insurability, including condition arising out of acts of domestic violence; or
   h. Disability.

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

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

(1) Was covered under qualifying previous coverage at the time of the initial enrollment;
(2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and
(3) Requests enrollment within thirty days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

d. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.

22. "Medical care" means amounts paid for:
a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
b. Transportation primarily for and essential to medical care referred to in subdivision a; and
c. Insurance covering medical care referred to in subdivisions a and b.

23. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

24. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

25. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

26. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

27. "Producer" means insurance producer.

28. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under any of the following:
a. A group health benefit plan;
b. A health benefit plan;
c. Medicare;
d. Medicaid;
e. Civilian health and medical program for uniformed services;
f. A medical care program of the Indian health service or of a tribal organization;
g. A state health benefit risk pool, including coverage issued under chapter 26.1-08;
h. A health plan offered under 5 U.S.C. 89;
i. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government;
j. A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and
k. A state's children's health insurance program funded through title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].

The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan" under subsection 17.

29. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

30. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.
31. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.
32. "Small employer" means, in connection with a group health plan with respect to a calendar and a plan year, an employer who employed an average of at least two but not more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.
33. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.
34. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.

(Effective after December 31, 2013) Definitions.

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

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the insurance commissioner, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
3. "Association" means, with respect to health insurance coverage offered in this state, an association that:
   a. Has been actively in existence for at least five years;
   b. Has been formed and maintained in good faith for purposes other than obtaining insurance;
   c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee or dependent of an employee;
   d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member; and
   e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.
4. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.
5. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.
6. "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].
7. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.
8. "Control" is as defined in section 26.1-10-01.
9. "Dependent" means a spouse, an unmarried child, including a dependent of an unmarried child, under the age of twenty-two, an unmarried child who is a full-time student under the age of twenty-six and who is financially dependent upon the

enrollee, and an unmarried child, including a dependent of an unmarried child, of any age who is medically certified as disabled and dependent upon the enrollee as set forth in section 26.1-36-22.

10. "Eligible employee" means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.
11. "Enrollee" means a person covered under a small employer health benefit plan.
12. "Established geographic service area" means a geographic area, as approved by the insurance commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
13. "Governmental plan" means an employee welfare benefit plan as defined in section 3(32) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.
14. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this chapter:
    a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, must be treated as an employee welfare benefit plan which is a group health benefit plan;
    b. In the case of a group health benefit plan, the term "employer" also includes the partnership in relationship to any partner; and
    c. In the case of a group health benefit plan, the term "participant" also includes:
        (1) In connection with a group health benefit plan maintained by a partnership, an individual who is a partner in relation to the partnership; or
        (2) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive benefits under the plan or the beneficiaries may be eligible to receive any benefit.
15. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract.
    b. "Health benefit plan" does not include one or more, or any combination of, the following:
        (1) Coverage only for accident, or disability income insurance, or any combination thereof;
        (2) Coverage issued as a supplement to liability insurance;
        (3) Liability insurance, including general liability insurance and automobile liability insurance;
        (4) Workforce safety and insurance or similar insurance;
        (5) Automobile medical payment insurance;
        (6) Credit-only insurance;
        (7) Coverage for onsite medical clinics; and
        (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance.

c. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
   (1) Limited scope dental or vision benefits;
   (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
   (3) Such other similar, limited benefits as are specified in federal regulations.

d. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits, and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
   (1) Coverage only for specified disease or illness; or
   (2) Hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:
   (1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
   (2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and
   (3) Similar supplemental coverage provided under a group health plan.

f. A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance shall comply with the following:
   (1) File with the insurance commissioner on or before March first of each year a certification that contains:
      (a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.
      (b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases when premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.
   (2) When the policy or certificate is offered for the first time in this state on or after August 1, 1993, file with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

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

17. "Health status-related factor" means any of the following factors:
   a. Health status;
   b. Medical condition, including both physical and mental illness;
   c. Claims experience;
   d. Receipt of health care;
   e. Medical history;
   f. Genetic information;
   g. Evidence of insurability, including condition arising out of acts of domestic violence; or
   h. Disability.

18. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.
19. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:
    a. The individual:
        (1) Was covered under qualifying previous coverage at the time of the initial enrollment;
        (2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and
        (3) Requests enrollment within thirty days after termination of the qualifying previous coverage.
    b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.
    c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.
    d. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.
20. "Medical care" means amounts paid for:
    a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
    b. Transportation primarily for and essential to medical care referred to in subdivision a; and
    c. Insurance covering medical care referred to in subdivisions a and b.
21. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.
22. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.
23. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].
24. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.
25. "Producer" means insurance producer.
26. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under any of the following:
    a. A group health benefit plan;
    b. A health benefit plan;
    c. Medicare;
    d. Medicaid;
    e. Civilian health and medical program for uniformed services;
    f. A medical care program of the Indian health service or of a tribal organization;
    g. A state health benefit risk pool, including coverage issued under chapter 26.1-08;
    h. A health plan offered under 5 U.S.C. 89;

i. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government;
j. A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and
k. A state's children's health insurance program funded through title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].

The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan".

27. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.
28. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.
29. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.
30. "Small employer" means, in connection with a group health plan with respect to a calendar and a plan year, an employer who employed an average of at least two but not more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.
31. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

26.1-36.3-02. Applicability and scope.

1. This chapter and section 26.1-36-37.2 apply to any health benefit plan that provides coverage to the employees of a small employer in this state if:
   a. Any portion of the premium or benefits is paid by or on behalf of the small employer;
   b. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or
   c. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the United States Internal Revenue Code.
2. a. Except as provided in subdivision b, carriers that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier and any restrictions or limitations imposed by this chapter and section 26.1-36-37.2 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier.
   b. An affiliated carrier that is a health maintenance organization having a certificate of authority may be considered to be a separate carrier for the purposes of this chapter and section 26.1-36-37.2.
   c. Unless otherwise authorized by the commissioner, a small employer carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if the arrangements would result in less than fifty percent of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.
3. a. A Taft Hartley trust, or a carrier with the written authorization of that trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of subsection 1 of section 26.1-36.3-04 with respect to a health benefit plan provided to the trust.
   b. The commissioner may grant the waiver if the commissioner finds that application of subsection 1 of section 26.1-36.3-04, with respect to the trust:
      (1) Would have a substantial adverse effect on the participants and beneficiaries of that trust; and

(2) Would require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

c. A waiver granted under this section does not apply to a person who participates in the trust as an associate member of an employee organization.

26.1-36.3-03. Establishment of classes of business.

1. A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs resulting from:
   a. The small employer carrier using more than one type of system for the marketing and sale of health benefit plans to small employers.
   b. The small employer carrier having acquired a class of business from another small employer carrier.
   c. The small employer carrier providing coverage to one or more association groups that meet the requirements set forth in rules adopted by the commissioner.
2. A small employer carrier may establish up to nine separate classes of business under subsection 1.
3. The commissioner may adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection 2 if the small employer carrier acquires an additional class of business from another small employer carrier.
4. The commissioner may approve the establishment of additional classes of business if the carrier applies to the commissioner and the commissioner determines that the action would enhance the efficiency and fairness of the small employer marketplace.

26.1-36.3-04. (Effective through December 31, 2013) Restrictions relating to premium rates.

1. This section only applies to a health benefit plan offered by a small employer who employed an average of at least two but not more than twenty-five eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.
2. Premium rates for health benefit plans subject to this section and section 26.1-36-37.2 are subject to the following:
   a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than fifteen percent.
   b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to the employers under the rating system for that class of business, may not vary from the index rate by more than twenty percent of the index rate.
   c. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:
      (1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;
      (2) Any adjustment due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; however, the adjustment may not exceed fifteen percent annually and must be adjusted pro rata for rating periods of less than one year; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

d. Adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents. Premium rates charged for a health benefit plan may not vary by a ratio of greater than four to one after January 1, 1997. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

e. A small employer carrier may utilize industry as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

f. In the case of health benefit plans delivered or issued for delivery before August 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions a and b for a period of three years following August 1, 1993. Under this subdivision, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

g. (1) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(2) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

h. For the purposes of this subsection, a health benefit plan that uses a restricted provider network may not be considered similar coverage to a health benefit plan that does not use a restricted provider network, if the use of the restricted provider network results in substantial differences in claims costs.

i. A small employer carrier may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size, without prior approval of the commissioner. Gender may not be used as a case characteristic after January 1, 1996.

j. The commissioner shall adopt rules to:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(2) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(3) Otherwise implement this section.

3. A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small

employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage.

4. The commissioner may suspend for a specified period the application of subdivision a of subsection 2 as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the small employer carrier or, with the prior approval of the committee established pursuant to section 26.1-36.3-08, that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.
5. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:
   a. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;
   b. The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;
   c. The provisions relating to renewability of policies and contracts; and
   d. The provisions relating to any preexisting condition exclusion.
6. a. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
   b. Each small employer carrier shall file with the commissioner on or before March fifteenth of each year an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification must be in a form and manner and contain information specified by the commissioner. The small employer carrier shall retain a copy of the certification at the carrier's principal place of business.
   c. A small employer carrier shall make the information and documentation described in subdivision a available to the commissioner upon request. Except in cases of violations of this chapter and section 26.1-36-37.2, the information is proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(Effective after December 31, 2013) Restrictions relating to premium rates.

1. This section only applies to a health benefit plan offered by a small employer who employed an average of at least two but not more than twenty-five eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.
2. Premium rates for health benefit plans subject to this section and section 26.1-36-37.2 are subject to the following:
   a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than fifteen percent.
   b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to the employers under the rating system for that class of business, may not vary from the index rate by more than twenty percent of the index rate.
   c. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(2) Any adjustment due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; however, the adjustment may not exceed fifteen percent annually and must be adjusted pro rata for rating periods of less than one year; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

d. Adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents. Premium rates charged for a health benefit plan may not vary by a ratio of greater than four to one after January 1, 1997. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

e. A small employer carrier may utilize industry as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

f. In the case of health benefit plans delivered or issued for delivery before August 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions a and b for a period of three years following August 1, 1993. Under this subdivision, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

g. (1) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(2) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

h. For the purposes of this subsection, a health benefit plan that uses a restricted provider network may not be considered similar coverage to a health benefit plan that does not use a restricted provider network, if the use of the restricted provider network results in substantial differences in claims costs.

i. A small employer carrier may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size, without

prior approval of the commissioner. Gender may not be used as a case characteristic after January 1, 1996.

j. The commissioner shall adopt rules to:
   (1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;
   (2) Prescribe the manner in which case characteristics may be used by small employer carriers; and
   (3) Otherwise implement this section.

3. A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage.
4. The commissioner may suspend for a specified period the application of subdivision a of subsection 2 as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.
5. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:
   a. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;
   b. The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;
   c. The provisions relating to renewability of policies and contracts; and
   d. The provisions relating to any preexisting condition exclusion.
6. a. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
   b. Each small employer carrier shall file with the commissioner on or before March fifteenth of each year an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification must be in a form and manner and contain information specified by the commissioner. The small employer carrier shall retain a copy of the certification at the carrier's principal place of business.
   c. A small employer carrier shall make the information and documentation described in subdivision a available to the commissioner upon request. Except in cases of violations of this chapter and section 26.1-36-37.2, the information is proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

26.1-36.3-05. Renewability of coverage.

1. A health benefit plan subject to this chapter and section 26.1-36-37.2 must be renewable with respect to all eligible employees and dependents, at the option of the small employer, except for any of the following:

a. The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments.
b. The plan sponsor or small employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the coverage.
c. Noncompliance with the carrier's minimum participation requirements.
d. Noncompliance with the carrier's employer contribution requirements.
e. A decision by the small employer carrier to discontinue offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the carrier in that market only if the carrier:
   (1) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;
   (2) Provides notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured individual is known to reside at least ninety days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries;
   (3) Offers to each plan sponsor provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the carrier to employers in the state; and
   (4) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under paragraph 3, the carrier acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.
f. A decision by the small employer carrier to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery to small employers in this state. In such a case, the carrier shall:
   (1) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;
   (2) Provide notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subdivision shall be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries; and
   (3) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and not renew coverage under any health benefit plan issued to a small employer.
g. In the case of health benefit plans that are made available in the small employer market only through one or more associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual.
h. The commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations. In this case the commissioner shall assist affected small employers in finding replacement coverage.

2. A small employer carrier that elects not to renew a health benefit plan under subdivision f of subsection 1 may not write new business in the small employer market in this state for a period of five years from the date of notice to the commissioner.

3. In the case of a small employer carrier doing business in one established geographic service area of the state, this section only applies to the carrier's operations in that service area.
4. A small employer carrier offering through a network plan may not be required to offer coverage or accept applications pursuant to subsection 1 or 2 in the case of the following:
   a. To an eligible person who no longer resides, lives, or works in the service area, or in an area for which the carrier is authorized to do business, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor; or
   b. To a small employer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the carrier, or the area for which the carrier is authorized to do business.
5. At the time of coverage renewal, a health insurance carrier may modify the health insurance coverage for a product offered to a group health plan if, for coverage that is available in such market other than only through one or more bona fide associations, the modification is reasonable, consistent with state law, and effective on a uniform basis among group health plans with that product. If coverage is modified, the carrier shall:
   a. Provide advance notice of its decision under this subsection to the commissioner at least three working days prior to mailing the notice to the affected small employers and participants and beneficiaries.
   b. Provide notice of the decision to modify health coverage to all affected small employers, participants, and beneficiaries and the commissioner sixty days prior to the modification of health coverage by the carrier.

26.1-36.3-06. (Effective through December 31, 2013) Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers all health benefit plans it actively markets to small employers in this state, including a basic health benefit plan and a standard health benefit plan.
   b. (1) Subject to subdivision a of subsection 1, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter and section 26.1-36-37.2. However, a carrier may not be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.
   (2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 26.1-36.3-03, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans it actively markets to small employers, including at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan, are not related to a health status-related factor of the small employer, and are applied consistently to all small employers applying for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.
2. a. A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard

health benefit plans to be used by the carrier. A health benefit plan filed under this subdivision may be used by a small employer carrier beginning sixty days after it is filed unless the commissioner disapproves its use.

b. The commissioner after providing notice and an opportunity for a hearing to the small employer carrier may disapprove, at any time, the continued use by a small employer carrier of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter and section 26.1-36-37.2.

3. Health benefit plans covering small employers must comply with the following:

a. A health benefit plan may impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;

(2) The exclusion extends for a period of not more than twelve months after the effective date of coverage;

(3) The exclusion does not relate to pregnancy as a preexisting condition; and

(4) The exclusion does not treat genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

b. A small employer carrier shall reduce any time period applicable to a preexisting condition exclusion or limitation period by the aggregate of periods the individual was covered by qualifying previous coverage, if any, if the qualifying previous coverage was continuous until at least sixty-three days prior to the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a group health benefit plan may not be taken into account in determining the period of continuous coverage. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan. Small employer carriers shall credit coverage by either a standard method or an alternative method. The commissioner shall adopt rules for crediting coverage under the standard and alternative method. These rules must be consistent with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any federal rules adopted pursuant thereto.

c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

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

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

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

(b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.

(4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

4. a. A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications under subsection 1 to a small employer if:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for such network plan; or

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier has demonstrated, if required, to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contractholders and enrollees, and that it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

b. A small employer carrier, upon denying health insurance coverage in any service area in accordance with paragraph 2 of subdivision a, may not offer coverage in the small employer market within the service area for a period of one hundred eighty days after the date the coverage is denied.

5. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that the carrier does not have the financial reserves to underwrite additional coverage and is applying this section uniformly without regard to the claims experience of small employers or any health status-related factor relating to employees and their dependents. A small employer carrier denying coverage in accordance with this section may not offer coverage in connection with a group health benefit plan in the small group market for a period of one hundred eighty days after the health coverage is denied or until the carrier has demonstrated to the commissioner sufficient financial reserves to underwrite financial coverage, whichever is later.

6. Subsection 1 does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

(Effective after December 31, 2013) Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers all health benefit plans it actively markets to small employers in this state.

b. (1) Subject to subdivision a of subsection 1, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the

plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter and section 26.1-36-37.2. However, a carrier may not be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 26.1-36.3-03, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans it actively markets to small employers. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan, are not related to a health status-related factor of the small employer, and are applied consistently to all small employers applying for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

2. Health benefit plans covering small employers must comply with the following:

a. A health benefit plan may impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;

(2) The exclusion extends for a period of not more than twelve months after the effective date of coverage;

(3) The exclusion does not relate to pregnancy as a preexisting condition; and

(4) The exclusion does not treat genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

b. A small employer carrier shall reduce any time period applicable to a preexisting condition exclusion or limitation period by the aggregate of periods the individual was covered by qualifying previous coverage, if any, if the qualifying previous coverage was continuous until at least sixty-three days prior to the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a group health benefit plan may not be taken into account in determining the period of continuous coverage. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan. Small employer carriers shall credit coverage by either a standard method or an alternative method. The commissioner shall adopt rules for crediting coverage under the standard and alternative method. These rules must be consistent with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any federal rules adopted pursuant thereto.

c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

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

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

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

(b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.

(4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

3. a. A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications under subsection 1 to a small employer if:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for such network plan; or

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier has demonstrated, if required, to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contractholders and enrollees, and that it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

b. A small employer carrier, upon denying health insurance coverage in any service area in accordance with paragraph 2 of subdivision a, may not offer coverage in the small employer market within the service area for a period of one hundred eighty days after the date the coverage is denied.

4. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that the carrier does not have the financial reserves to underwrite additional coverage and is applying this section uniformly without regard to the claims experience of small employers or any health status-related factor relating to employees and their dependents. A small employer carrier denying coverage in accordance with this section may not offer coverage in connection with a group health benefit plan in the small group market for a period of one hundred eighty days after the health coverage

is denied or until the carrier has demonstrated to the commissioner sufficient financial reserves to underwrite financial coverage, whichever is later.

5. Subsection 1 does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

26.1-36.3-07. Small employer carrier reinsurance program.

Repealed by S.L. 2003, ch. 256, § 3.

26.1-36.3-08. (Repealed effective January 1, 2014) Health benefit plan committee.

1. The insurance commissioner shall appoint a health benefit plan committee composed of representatives of carriers, small employers, employees, health care providers, and producers.
2. The committee shall recommend the form and level of coverage to be made available by a small employer carrier pursuant to section 26.1-36.3-06.
3. The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan each of which contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefits of health maintenance organizations, including any restrictions imposed by federal law.
   a. The plans recommended by the committee may include cost containment features such as:
      (1) Utilization review of health care services, including review of medical necessity of hospital and physician services;
      (2) Case management;
      (3) Selective contracting with hospitals, physicians, and other health care providers;
      (4) Reasonable benefit differentials applicable to providers that do or do not participate in arrangements using restricted network provisions; and
      (5) Other managed care provisions.
   b. The committee shall submit the health benefit plans described in this subsection to the commissioner for approval within one hundred eighty days after the appointment of the committee.

26.1-36.3-09. Periodic market evaluation.

Repealed by S.L. 2003, ch. 256, § 3.

26.1-36.3-10. (Repealed effective January 1, 2014) Waiver of certain state laws.

Any law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner, does not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state under this chapter and section 26.1-36-37.2.

26.1-36.3-11. (Effective through December 31, 2013) Standards to assure fair marketing.

1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state.
2. a. A small employer carrier or producer may not engage in the following activities, directly or indirectly:
      (1) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(2) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

b. Subdivision a does not apply to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. a. A small employer carrier may not enter into any contract, agreement, or arrangement, directly or indirectly, with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

b. Subdivision a does not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided the percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

4. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

5. No small employer carrier may terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

6. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

7. Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

8. A violation of this section by a small employer carrier or a producer is an unfair trade practice under section 26.1-04-03.

9. If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator is subject to this section as if it were a small employer carrier.

(Effective after December 31, 2013) Standards to assure fair marketing.

1. Each small employer carrier shall actively market health benefit plan coverage to eligible small employers in the state.

2. a. A small employer carrier or producer may not engage in the following activities, directly or indirectly:

(1) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(2) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

b. Subdivision a does not apply to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. a. A small employer carrier may not enter into any contract, agreement, or arrangement, directly or indirectly, with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

b. Subdivision a does not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided the

percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

4. No small employer carrier may terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.
5. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.
6. Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.
7. A violation of this section by a small employer carrier or a producer is an unfair trade practice under section 26.1-04-03.
8. If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator is subject to this section as if it were a small employer carrier.

26.1-36.3-12. Restoration of terminated coverage.

The commissioner may adopt rules to require small employer carriers, as a condition of transacting business with small employers in this state after August 1, 1993, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or has not been renewed by the carrier after January 1, 1994. The rules may contain terms for the reissue of coverage as the commissioner determines necessary to provide continuity of coverage to small employers.