CHAPTER 26.1-36.4
HOSPITAL AND MEDICAL INSURANCE

26.1-36.4-01. Application and scope.

This chapter applies to all policies issued or renewed after July 31, 1995. The provisions of chapter 26.1-36 apply when not in conflict with this chapter.

26.1-36.4-02. Definitions.

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

1. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization that provides a plan of health insurance or health benefits subject to state insurance regulation.
2. "Policy" means any health benefit plan as defined in section 26.1-36.3-01, whether offered on a group or individual basis. The term does not include short-term major medical policies offered in the individual market.
3. "Short-term", except as required by the Health Insurance Portability and Accountability Act of 1996, means a policy or plan providing coverage for one hundred eighty-five days or less.

26.1-36.4-03. Limits on preexisting condition exclusions.

An insurer 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 diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of the person's coverage.
2. The exclusion extends for a period of not more than twelve months after the effective date of coverage. A group policy may impose an eighteen-month preexisting condition to a late enrollee, as the term late enrollee is defined in section 26.1-36.3-01.

26.1-36.4-03.1. Additional limits on preexisting condition exclusions.

A group policy may not impose a preexisting condition exclusion that:

1. Relates to pregnancy as a preexisting condition.
2. Treats genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

26.1-36.4-04. Portability of insurance policies.

An insurer shall reduce any time period applicable to a preexisting condition, for a policy by the aggregate of periods the individual was covered by qualifying previous coverage, if the qualifying previous coverage as defined in section 26.1-36.3-01 is continuous until at least sixty-three days before the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a health benefit plan may not be taken into account in determining the period of continuous coverage. Insurers shall credit coverage in the same manner as provided by section 26.1-36.3-06 and the rules adopted by the commissioner pursuant thereto.

26.1-36.4-05. Renewability of health insurance coverage - Discrimination prohibited.

1. An insurer issuing policies or certificates under this chapter shall provide for the renewability or continuability of coverage unless:
   a. The individual or group has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the insurer has not received timely premium payments.
   b. The individual or group 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 insurer's minimum group participation requirements.

d. Noncompliance with the insurer's employer group contribution requirements.

e. A decision by the insurer to discontinue offering a particular type of health insurance coverage in the group or individual market. A type of group health benefit plan or individual policy may be discontinued by the insurer in that market only if the insurer:

(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 individuals, employers, participants, beneficiaries, and to the commissioner in each state in which an affected insured is known to reside at least ninety days prior to the nonrenewal of any health benefit plans by the insurer. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected individuals, employers, participants, and beneficiaries;

(3) Offers to each affected group or individual the option to purchase all other health benefit plans or individual coverage currently being offered by the insurer in that market; and

(4) In exercising the option to discontinue the particular type of group health benefit plan or individual coverage and in offering the option of coverage under paragraph 3, the insurer acts uniformly without regard to claims experience or any health status-related factor relating to any affected individuals, participants, or beneficiaries covered or new individuals, participants, or beneficiaries who may become eligible for such coverage.

f. A decision by the insurer to discontinue offering and to nonrenew all its health benefit plans or individual coverage delivered or issued for delivery to employers or individuals in this state. In such a case, the insurer shall:

(1) Provide 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 individuals, employers, participants, and beneficiaries, and to the commissioner in each state in which an affected insured is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the insurer. Notice to the commissioner under this subdivision must be provided at least three working days prior to the notice to the affected individuals, employers, participants, and beneficiaries; and

(3) Discontinue all health insurance issued or delivered for issuance in the state's group or individual market and not renew such health coverage in that market.

g. In the case of health benefit plans that are made available in the group or individual market only through one or more associations, the membership of an employer or individual in the association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated under this paragraph 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 insurer's ability to meet its contractual obligations. In this case the commissioner shall assist affected insureds in finding replacement coverage.

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

3. In the case of an insurer doing business in one established geographic service area of the state, this section only applies to the insurer's operations in that service area.

4. An insurer offering coverage 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 insurer 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 an insurer that no longer has any enrollee in connection with the plan who lives, resides, or works in the service area of the insurer, or the area for which the insurer is authorized to do business.

5. At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered to a group or individual, if the modification is reasonable, consistent with state law, and effective on a uniform basis. 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 employers and participants and beneficiaries.
   b. Provide notice of the decision to modify health coverage to all affected employers, participants, and beneficiaries and the commissioner sixty days prior to the modification of health coverage by the carrier.

26.1-36.4-06. Modified community rating.

Premium rates for individual policies are subject to the following:

1. For any class of individuals, the premium rates charged during a rating period to the individuals in that class for the same or similar coverage may not vary by a ratio of more than six to one after August 1, 1995, and by a ratio of more than five to one after August 1, 1996, when age, industry, gender, and duration of coverage of the individuals are considered. Gender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997.
2. An insurer, in addition to the factors set forth in subsection 1, may use geography, family composition, healthy lifestyles, and benefit variations to determine premium rates.
3. The commissioner shall design and adopt reporting forms to be used by an insurer to report information as to insurer's experience as to insurance provided under this chapter on a periodic basis to determine the impact of the reforms and implementation of modified community rating contained in this chapter.

26.1-36.4-07. (Repealed effective January 1, 2014) Health benefits package required.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual or group basis unless the company, corporation, or association actively offers a basic health benefit plan and a standard health benefit plan as approved by the commissioner. The commissioner shall design and adopt a basic health benefit plan and a standard health benefit plan to be offered on an individual and group basis as required by this section. The basic and standard health benefit plans must be those developed under section 26.1-36.3-06. This section does not require a health maintenance organization to provide any benefit it is prohibited from providing under federal law and does not excuse failure to provide benefits mandated by federal law.

26.1-36.4-08. Employer payment of employee premium.

An insurer shall accept a personal or business check from an employer as a payment method for premium payment for an employee's individual accident and health insurance policy. This section does not apply to groups as defined under chapter 26.1-36.3.

26.1-36.4-09. Health insurance utilization reports.

1. Once each calendar year, any employer with fifty-one or more eligible employees or upon termination of health insurance coverage for any employer, the employer is entitled to a report from the insurer or administrator of that employer's employee health

plan which includes a monthly accounting for the most recent twenty-four-month period of the total number of insured or covered employees, the total premiums paid, and the total benefits paid on behalf of the employer's health plan.

2. Insurers shall provide the report pursuant to subsection 1 to an employer within thirty days of receipt of a request for the information.
3. The information provided pursuant to subsection 1 may not identify specific employee claims or other confidential health care information.
4. Upon notification of termination of health insurance before the end of a benefit period, the terminated insurer, at the request of the employer and within thirty days of the request, shall supply the succeeding or new insurer a report of all deductibles and coinsurance payments for each employee covered by the employer's health insurance plan for the most recent benefit period.