CHAPTER 54-52.1
UNIFORM GROUP INSURANCE PROGRAM

54-52.1-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board" means the public employees retirement board.
2. "Carrier" means:
   a. For the hospital benefits coverage, an insurance company authorized to do business in the state, or a nonprofit hospital service association, or a prepaid group practice hospital care plan authorized to do business in the state, or the state if a self-insurance plan is used for providing hospital benefits coverage.
   b. For the medical benefits coverage, an insurance company authorized to do business in the state, or a nonprofit medical service association, or a prepaid group practice medical care plan authorized to do business in the state, or the state if a self-insurance plan is used for providing medical benefits coverage.
   c. For the life insurance benefits coverage, an insurance company authorized to do business in the state.
3. "Department, board, or agency" means the departments, boards, agencies, or associations of this state, and includes the state's charitable, penal, and higher educational institutions; the Bank of North Dakota; the state mill and elevator association; and counties, cities, district health units, and school districts.
4. "Eligible employee" means every permanent employee who is employed by a governmental unit, as that term is defined in section 54-52-01. "Eligible employee" includes members of the legislative assembly, judges of the supreme court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by subsection 2 of section 54-06-01, and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund. As used in this subsection, "permanent employee" means one whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. For purposes of sections 54-52.1-04.1, 54-52.1-04.7, 54-52.1-04.8, and 54-52.1-11, "eligible employee" includes retired and terminated employees who remain eligible to participate in the uniform group insurance program pursuant to applicable state or federal law.
5. "Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter 26.1-18.1.
6. "Hospital benefits coverage" means a plan which either provides coverage for, or pays, or reimburses expenses for hospital services incurred in accordance with the uniform contract.
7. "Life insurance benefits coverage" means a plan which provides both term life insurance and accidental death and dismemberment insurance in amounts determined by the board, with a minimum of one thousand dollars provided for the term life insurance portion of the coverage.
8. "Medical benefits coverage" means a plan which either provides coverage for, or pays, or reimburses expenses for medical services in accordance with the uniform contract.
9. "Member contribution" means the payment by the member into the retiree health benefits fund pursuant to sections 54-52-02.9 and 54-52-17.4.
10. "Member's account balance" means the member's contributions plus interest at the rate set by the board.
11. "Temporary employee" means a governmental unit employee who is not filling an approved and regularly funded position in an eligible governmental unit and whose services may or may not be limited in duration.

54-52.1-02. Uniform group insurance program created - Formation into subgroups.

In order to promote the economy and efficiency of employment in the state's service, reduce personnel turnover, and offer an incentive to high-grade individuals to enter and remain in the service of state employment, there is created a uniform group insurance program. The uniform group must be composed of eligible and retired employees and be formed to provide hospital benefits coverage, medical benefits coverage, and life insurance benefits coverage in the manner set forth in this chapter. The uniform group may be divided into the following subgroups at the discretion of the board:

1. Medical and hospital benefits coverage group consisting of active eligible employees and retired employees not eligible for medicare, except for employees who first retire after the effective date of this section and are not eligible for medicare on their retirement. In determining premiums for coverage under this subsection for retired employees not eligible for medicare, the rate for a non-medicare retiree single plan is one hundred fifty percent of the active member single plan rate, the rate for a non-medicare retiree family plan of two people is twice the non-medicare retiree single plan rate, and the rate for a non-medicare retiree family plan of three or more persons is two and one-half times the non-medicare retiree single plan rate.
2. In addition to the coverage provided in subsection 1, another coverage option may be provided for retired employees not eligible for medicare, except for employees who first retire after the effective date of this section and are not eligible for medicare on their retirement, provided the option does not increase the implicit subsidy as determined by the governmental accounting standards board's other postemployment benefit reporting procedure. In offering this additional option, the board may have an open enrollment but thereafter enrollment for this option must be as specified in section 54-52.1-03.
3. Retired medicare-eligible employee group medical and hospital benefits coverage.
4. Active eligible employee life insurance benefits coverage.
5. Retired employee life insurance benefits coverage.
6. Terminated employee continuation group medical and hospital benefits coverage.
7. Terminated employee conversion group medical and hospital benefits coverage.
8. Dental benefits coverage.
9. Vision benefits coverage.
10. Long-term care benefits coverage.
11. Employee assistance benefits coverage.
12. Prescription drug coverage.

54-52.1-03. Employee participation in plan - Employee to furnish information - Benefits to continue upon retirement or termination.

1. Any eligible employee may be enrolled in the uniform group insurance program created by this chapter by requesting enrollment with the employing department. If an eligible employee does not enroll in the uniform group insurance program at the time of beginning employment, in order to enroll at a later time the eligible employee must meet minimum requirements established by the board. An employing department may not require an active eligible employee to request coverage under the uniform group insurance program as a prerequisite to receive the minimum employer-paid life insurance benefits coverage or employee assistance program benefits coverage.
2. Within five days after the expiration of the payroll period during which enrollment was requested, the employing department shall enroll the employee with the board. The employee's insurance coverage becomes effective on the date of enrollment.
3. A retiree who has accepted a periodic distribution from the defined contribution retirement plan pursuant to section 54-52.6-13 who the board determines is eligible for participation in the uniform group insurance program or has accepted a retirement allowance from the public employees retirement system, the highway patrolmen's retirement system, the teachers' insurance and annuity association of America - college retirement equities fund for service credit earned while employed by North Dakota institutions of higher education, the retirement system established by job

service North Dakota under section 52-11-01, the judges' retirement system established under chapter 27-17, or the teachers' fund for retirement may elect to participate in the uniform group under this chapter without meeting minimum requirements at age sixty-five, when the member's spouse reaches age sixty-five, upon the receipt of a benefit, or when the spouse terminates employment. If a retiree or surviving spouse does not elect to participate at the times specified in this subsection, the retiree or surviving spouse must meet the minimum requirements established by the board. Subject to sections 54-52.1-03.2 and 54-52.1-03.3, each retiree or surviving spouse shall pay directly to the board the premiums in effect for the coverage then being provided. A retiree or surviving spouse who has met the initial eligibility requirements of this subsection to begin participation in the uniform group insurance program remains eligible as long as the retiree maintains the retiree's participation in the program by paying the required premium pursuant to rules adopted by the board.

4. Upon the termination of employment when the employee is not eligible to participate under subsection 3 or 5 or applicable federal law, that employee cannot continue as a member of the uniform group.
5. A member or former member of the legislative assembly or that person's surviving spouse may elect to continue membership in the uniform group within the applicable time limitations after either termination of eligible employment as a member of the legislative assembly or termination of other eligible employment or, for a surviving spouse, upon the death of the member or former member of the legislative assembly. The member or former member of the legislative assembly or that person's surviving spouse shall pay the premiums in effect for the coverage provided directly to the board.
6. Each eligible employee requesting enrollment shall furnish the appropriate person in the employing department, board, or agency with such information and in such form as prescribed by the board to enable the enrollment of the employee, or employee and dependents, in the uniform group insurance program created by this chapter.
7. If the participating employee is a faculty member in a state charitable, penal, or educational institution who receives a salary or wages on less than a twelve-month basis and has signed a contract to teach for the next ensuing school year, the agency shall make arrangements to include that employee in the insurance program on a twelve-month basis and make the contribution authorized by this section for each month of the twelve-month period.

54-52.1-03.1. Certain political subdivisions authorized to join uniform group insurance program - Employer contribution.

If eligible under federal law, a political subdivision may extend the benefits of the uniform group insurance program under this chapter to its permanent employees, subject to minimum requirements established by the board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation in the uniform group insurance program, before completing sixty months of participation, unless federal or state laws or rules are modified or interpreted in a way that makes participation by the political subdivision in the uniform group insurance program no longer allowable or appropriate, the political subdivision shall make payment to the board in an amount equal to any expenses incurred in the uniform group insurance program that exceed income received on behalf of the political subdivision's employees as determined under rules adopted by the board. The Garrison Diversion Conservancy District, and district health units required to participate in the public employees retirement system under section 54-52-02, shall participate in the uniform group insurance program under the same terms and conditions as state agencies. A retiree who has accepted a retirement allowance from a participating political subdivision's retirement plan may elect to participate in the uniform group under this chapter without meeting minimum requirements at age sixty-five, when the employee's spouse reaches age sixty-five, upon the receipt of a benefit, when the political subdivision joins the uniform group insurance plan if the retiree was a member of the former plan, or when the spouse terminates employment. If a retiree or surviving spouse

does not elect to participate at the times specified in this section, the retiree or surviving spouse must meet the minimum requirements established by the board. Each retiree or surviving spouse shall pay directly to the board the premiums in effect for the coverage then being provided. The board may require documentation that the retiree has accepted a retirement allowance from an eligible retirement plan other than the public employees retirement system.

54-52.1-03.2. Retiree health benefits fund - Appropriation.

1. The board shall establish a retiree health benefits fund account with the Bank of North Dakota for the purpose of prefunding and providing hospital benefits coverage and medical benefits coverage and prescription drug coverage under any health insurance program and dental, vision, and long-term care benefits coverage under the uniform group insurance program for retired eligible employees or surviving spouses of retired eligible employees and their dependents as provided in this chapter. The state shall contribute monthly to the retiree health benefits fund an amount equal to one and fourteen hundredths percent of the monthly salaries and wages of all participating members of the highway patrolmen's retirement system under chapter 39-03.1, and one and fourteen hundredths percent of the monthly salaries of all supreme or district court judges who are participating members of the public employees retirement system under chapter 54-52. Each governmental unit that contributes to the public employees retirement system fund under section 54-52-06 or the retirement plan under chapter 54-52.6 shall contribute monthly to the retiree health benefits fund an amount equal to one and fourteen hundredths percent of the monthly salaries or wages of all participating members of the public employees retirement system under chapter 54-52 or chapter 54-52.6, except for nonteaching employees of the superintendent of public instruction who elect to participate in the public employees retirement system pursuant to section 54-52-02.13 and employees of the state board for career and technical education who elect to participate in the public employees retirement system pursuant to section 54-52-02.14. For nonteaching employees of the superintendent of public instruction who elect to participate in the public employees retirement system pursuant to section 54-52-02.13, the superintendent of public instruction shall contribute monthly to the retiree health benefits fund an amount equal to three and twenty-four hundredths percent of the monthly salaries or wages of those nonteaching employee members, beginning on the first of the month following the transfer under section 54-52-02.13 and continuing thereafter for a period of eight years, after which time the superintendent of public instruction shall contribute one and fourteen hundredths percent of the monthly salary or wages of those nonteaching employee members. For employees of the state board for career and technical education who elect to participate in the public employees retirement system pursuant to section 54-52-02.14, the state board for career and technical education shall contribute monthly to the retiree health benefits fund an amount equal to two and ninety-nine hundredths percent of the monthly salary or wages of those employee members, beginning on the first of the month following the transfer under section 54-52-02.14 and continuing thereafter for a period of eight years, after which time the state board for career and technical education shall contribute one and fourteen hundredths percent of the monthly salary or wages of those employee members. The employer of a national guard security officer or firefighter shall contribute monthly to the retiree health benefits fund an amount equal to one and fourteen hundredths percent of the monthly salaries or wages of all national guard security officers or firefighters participating in the public employees retirement system under chapter 54-52. Job service North Dakota shall reimburse monthly the retiree health benefits fund for credit received under section 54-52.1-03.3 by members of the retirement program established by job service North Dakota under section 52-11-01. The board, as trustee of the fund and in exclusive control of its administration, shall:
   a. Provide for the investment and disbursement of moneys of the retiree health benefits fund and administrative expenditures in the same manner as moneys of the public employees retirement system are invested, disbursed, or expended.

b. Adopt rules necessary for the proper administration of the retiree health benefits fund, including enrollment procedures.

2. All moneys deposited in the fund established under subsection 1, not otherwise appropriated, are hereby appropriated to the board for the purpose of making investments for the fund and to make contributions toward hospital and medical benefits coverage and prescription drug coverage under any health insurance program and dental, vision, and long-term care benefits coverage under the uniform group insurance program for eligible retired employees or surviving spouses of eligible retired employees and their dependents as elected.

3. If a member terminates employment because of death, permanent and total disability, or any voluntary or involuntary reason prior to retirement, the member or the member's designated beneficiary is entitled to the member's account balance at termination. If a member's account balance is withdrawn, the member relinquishes all rights to benefits under the retiree health benefits fund.

54-52.1-03.3. Eligibility for retiree health benefits - Fixed contribution and reduction factors.

1. The following persons are entitled to receive credit for hospital and medical benefits coverage and prescription drug coverage under any health insurance program and dental, vision, and long-term care benefits coverage under the uniform group insurance program under subsection 2:
   a. A member or surviving spouse of the highway patrolmen's retirement system is eligible for the credit beginning on the date retirement benefits are effective unless the premium is billed to the employer.
   b. A member or surviving spouse of the public employees retirement system is eligible for the credit beginning on the date retirement benefits are effective unless the premium is billed to the employer.
   c. A member or surviving spouse of the retirement program established by job service North Dakota under section 52-11-01 receiving retirement benefits is eligible for the credit beginning on the date retirement benefits are effective unless the premium is billed to the employer.
   d. A retired judge or surviving spouse receiving retirement benefits under the retirement program established under chapter 27-17 is eligible for the credit beginning on the date retirement benefits are effective unless the premium is billed to the employer.
   e. A former participating member of the defined contribution retirement plan receiving retirement benefits, or the surviving spouse of a former participating member of that retirement plan who was eligible to receive or was receiving benefits, under section 54-52.6-13, is eligible as determined by the board pursuant to its rules.

2. The board shall calculate the allowable monthly credit toward hospital and medical benefits coverage and prescription drug coverage under any health insurance program and dental, vision, and long-term care benefits coverage under the uniform group insurance program for a person eligible under subsection 1 in an amount equal to five dollars multiplied by the member's or deceased member's number of years of credited service under the highway patrolmen's retirement system, the public employees retirement system, the retirement program established by job service North Dakota under section 52-11-01, or the judges' retirement program established under chapter 27-17. For a member of the public employees retirement system receiving an early retirement benefit or the surviving spouse of that member, or a former participating member of the defined contribution retirement plan who is receiving a periodic distribution and would not meet the normal retirement provisions of the public employees retirement system, the allowable monthly credit must be reduced by three percent if the member terminates employment within one year prior to attaining the age of sixty-five and an additional reduction factor of six percent shall apply for each year the member terminates employment prior to attaining the age of sixty-four. For a

member of the highway patrolmen's retirement system receiving an early retirement benefit or the surviving spouse of that member, the allowable monthly credit must be reduced by three percent if the member terminates employment within one year prior to attaining the age of fifty-five and an additional reduction factor of six percent shall apply for each year the member terminates employment prior to attaining the age of fifty-four. For a member of the retirement program established by job service North Dakota under section 52-11-01 receiving an early retirement benefit or a discontinued service annuity under the plan provisions of that retirement program or the surviving spouse of that member, the allowable monthly credit must be reduced by three percent if the member terminates employment within one year prior to attaining the age of sixty-five and an additional reduction factor of six percent applies for each year the member terminates employment prior to attaining the age of sixty-four.

3. The board shall apply the credit allowable under subsection 2 as elected by the eligible participant to the payment of monthly premiums required of each person eligible under subsection 1 for hospital benefits coverage and medical benefits coverage and prescription drug coverage under any health insurance program and dental, vision, and long-term care benefits coverage under the uniform group insurance program. The board shall allow spouses who each have credit under subsection 2 to combine their credits and shall apply the combined credit to the required monthly premiums as elected pursuant to this subsection. However, if the allowable credit under any circumstance exceeds the monthly premium in effect for selected coverage, that amount of the credit which exceeds the premium is forfeited and may not be used for any other purpose.
4. The board may, as an alternative to the calculation of the allowable monthly credit under subsection 2, provide actuarially reduced benefit options for the member and the member's surviving spouse, including a one hundred percent joint and survivor option or a fifty percent joint and survivor option.

54-52.1-03.4. Temporary employees and employees on unpaid leave of absence.

A temporary employee employed before August 1, 2007, may elect to participate in the uniform group insurance program by completing the necessary enrollment forms and qualifying under the medical underwriting requirements of the program if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under section 4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)]. Monthly, the temporary employee or the temporary employee's employer shall pay to the board the premiums in effect for the coverage being provided. In the case of a temporary employee who is an applicable taxpayer as defined in section 36B(c)(1)(A) of the Internal Revenue Code [26 U.S.C. 36B(c)(1)(A)], the temporary employee's required contribution for medical and hospital benefits self-only coverage may not exceed the maximum employee required contribution specified under section 36B(c)(2)(C) of the Internal Revenue Code [26 U.S.C. 36B(c)(2)(C)], and the employer shall pay any difference between the maximum employee required contribution for medical and hospital benefits self-only coverage and the cost of the premiums in effect for this coverage. An employer may pay health or life insurance premiums for a permanent employee on an unpaid leave of absence. A political subdivision, department, board, or agency may make a contribution for coverage under this section.

54-52.1-04. Board to contract for insurance.

The board shall receive bids for the providing of hospital benefits coverage, medical benefits coverage, life insurance benefits coverage for a specified term, and employee assistance program services; may receive bids separately for prescription drug coverage; and shall accept one or more bids of and contract with the carriers that in the judgment of the board best serves the interests of the state and its eligible employees. Solicitations must be made not later than ninety days before the expiration of an existing uniform group insurance contract. Bids must be solicited by advertisement in a manner selected by the board that will provide reasonable notice to prospective bidders. In preparing bid proposals and evaluating bids, the board may utilize the services of consultants on a contract basis in order that the bids received may be uniformly compared and properly evaluated. In determining which bid, if any, will best serve the interests of eligible employees and the state, the board shall give adequate consideration to the following factors:

1. The economy to be effected.
2. The ease of administration.
3. The adequacy of the coverages.
4. The financial position of the carrier, with special emphasis as to its solvency.
5. The reputation of the carrier and any other information that is available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

The board may reject any or all bids and, in the event it does so, shall again solicit bids as provided in this section. The board may establish a plan of self-insurance for providing health insurance benefits coverage only under an administrative services only (ASO) contract or a third-party administrator (TPA) contract.

54-52.1-04.1. Health maintenance organization contract - Membership option.

Notwithstanding the provisions of section 54-52.1-04, the board may contract with one or more health maintenance organizations to provide eligible employees the option of membership in a health maintenance organization. If it makes such a contract, the board may not require that the health maintenance organization be federally qualified if the health maintenance organization has a certificate of authority issued by the North Dakota insurance commissioner. The contract or contracts must be included in the uniform group insurance program.

54-52.1-04.2. Self-insurance plan for hospital and medical benefits coverage.

1. The board may establish a self-insurance plan for providing:
   a. Health insurance benefits coverage;
   b. Health insurance benefits coverage excluding all or part of prescription drug coverage; or
   c. All or part of prescription drug coverage.
2. Any self-insurance plan under this section must be provided under an administrative services only (ASO) contract or a third-party administrator (TPA) contract under the uniform group insurance program, and may be established only if it is determined by the board that an administrative services only or third-party administrator plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits. Upon establishing a self-insurance plan, the board shall solicit bids for an administrative services only or third-party administrator contract only every other biennium, and the board is authorized to renegotiate an existing administrative services only or third-party administrator contract during the interim. In addition, individual stop-loss coverage insured by a carrier authorized to do business in this state must be made part of any self-insured plan. All bids under this section are due no later than January first, and must be awarded no later than March first, preceding the end of each biennium. All bids under this section must be opened at a public meeting of the board.

54-52.1-04.3. Contingency reserve fund - Continuing appropriation.

The board shall establish under a self-insurance plan a contingency reserve fund to provide for adverse fluctuations in future charges, claims, costs, or expenses of the uniform group insurance program. The board shall determine the amount necessary to provide a balance in the contingency reserve fund between one and one-half months and three months of claims paid based on the average monthly claims paid during the twelve-month period immediately preceding March first of each year. The board also shall determine the amount necessary to provide an additional balance in the contingency reserve fund between one month and one and one-half months for claims incurred but not yet reported. The board may arrange for the services of an actuarial consultant to assist the board in making these determinations. Upon the initial changeover from a contract for insurance pursuant to section 54-52.1-04 to a self-insurance plan pursuant to section 54-52.1-04.2, the board must have a plan in place which is reasonably calculated to meet the funding requirements of this chapter within sixty months. All moneys in the contingency reserve fund, not otherwise appropriated, are appropriated for the payment of claims and other costs of the uniform group insurance program during periods of adverse claims or cost fluctuations.

54-52.1-04.4. Insurance to cover mammogram examinations.

The board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for:

1. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.
2. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age.

54-52.1-04.5. Insurance to cover involuntary complications of pregnancy.

Medical benefits coverage provided under either a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 may not contain any exclusion, reduction, or other limitation as to coverage, deductible, or coinsurance provision, as to involuntary complications of pregnancy unless the provisions apply generally to all benefits paid under the coverage. If a fixed amount is specified for in the coverage for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy must be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case when a fixed amount is payable for maternity benefits, involuntary complications of pregnancy are an illness and entitled to benefits otherwise provided by the coverage. When the coverage contains a maternity deductible, the maternity deductible applies only to expenses resulting from normal delivery and caesarean section delivery; however, expenses for caesarean section delivery in excess of the deductible must be treated as expenses for any other illness under the coverage. For purposes of this section, "involuntary complications of pregnancy" includes nonelective caesarean section delivery.

54-52.1-04.6. Coverage for treatment of certain disorders.

The board shall provide coverage under either a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage must be the same as that for treatment to any other joint in the body, and applies if the treatment is administered or prescribed by a physician or a dentist. Benefits for the coverage may be limited to a lifetime maximum of ten thousand dollars per person for surgery, and two thousand five hundred dollars for nonsurgical treatment.

54-52.1-04.7. Uniform group insurance program - Vision and dental plans.

The board may establish a dental plan, a vision plan, or both, for eligible employees. The board shall receive bids for the plan or plans pursuant to section 54-52.1-04. The board may reject any or all bids and provide a plan of self-insurance. Premiums for this coverage must be

paid by the eligible employee. Any refund, rebate, dividend, experience rating allowance, discount, or other reduction of premium must be credited as provided by section 54-52.1-06.

54-52.1-04.8. Uniform group insurance program - Long-term care plan.

The board may establish a long-term care plan for eligible employees. The board shall receive bids for the plan under section 54-52.1-04. The board may reject any or all bids and provide a plan of self-insurance. Premiums for this plan must be paid by the eligible employee. Any refund, rebate, dividend, experience rating allowance, discount, or other reduction of premium must be credited as provided by section 54-52.1-06.

54-52.1-04.9. Uniform group insurance program - Employee assistance program.

The board shall establish an employee assistance program available to persons in the medical and hospital benefits coverage group. The premium for this coverage must be paid as provided by section 54-52.1-06. The board shall receive bids for this program under section 54-52.1-04. Each department, board, or agency shall obtain employee assistance program services through the board for eligible employees and may not enter into any agreement to obtain employee assistance program services with a third-party provider except that a department, board, or agency may use its own employee assistance program services to the extent such services are provided by personnel of that department, board, or agency. As used in this section, "employee assistance program" means an employer-sponsored service for employees under which a professional employee assistance program staff assists employees and their families in finding help for emotional, drug, alcohol, family, health, and other personal or job-related problems that may be affecting their work performance.

54-52.1-04.10. Insurance to cover dental anesthesia and hospitalization.

The board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for dental anesthesia and hospitalization in the same manner as provided under section 26.1-36-09.9.

54-52.1-04.11. Insurance to cover foods and food products for inherited metabolic diseases.

The board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for foods and food products for inherited metabolic diseases in the same manner as provided for under section 26.1-36-09.7.

54-52.1-04.12. Insurance to cover medical services related to intoxication.

The board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52-04.2 for medical services related to intoxication in the same manner as provided for under subsection 15 of section 26.1-36-05 and section 26.1-36-09.13.

54-52.1-04.13. (Effective through July 31, 2017) Insurance coverage of telehealth services.

1. As used in this section:
   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
   b. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
   c. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

d. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
e. "Policy" means health benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2.
f. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.
g. "Telehealth":
(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site; and that is delivered over a secure connection that complies with the requirements of state and federal laws.
(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
(3) Does not include the use of audio-only telephone, electronic mail, or facsimile transmissions.

2. For all policies that become effective after June 30, 2015, and which do not extend past June 30, 2017, the board shall provide health benefits coverage under a policy that provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.
3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the board or the board's contractor with the health services providers in the same manner as the board establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.
4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.
5. This section does not require:
a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;
b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;
c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or
d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

54-52.1-04.14. Coverage of cancer treatment medications.

The board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 which provides coverage of cancer treatment medications in the same manner as provided under section 26.1-36-09.14.

54-52.1-05. Provisions of contract - Term of contract.

1. Each uniform group insurance contract entered by the board must be consistent with the provisions of this chapter, must be signed for the state of North Dakota by the chairman of the board, and must include the following:

a. As many optional coverages as deemed feasible and advantageous by the board.
b. A detailed statement of benefits offered, including maximum limitations and exclusions, and such other provisions as the board may deem necessary or desirable.

2. The initial term or the renewal term of a fully insured uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage may not exceed two years.
   a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations and the proposed premium renewal amount does not exceed the board's expectations.
   b. In making a determination under this subsection, the board shall:
      (1) Use the services of a consultant to concurrently and independently prepare a renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.
      (2) Review the carrier's performance measures, including payment accuracy, claim processing time, member service center metrics, wellness or other special program participation levels, and any other measures the board determines relevant to making the determination and shall consider these measures in determining the board's satisfaction with the carrier's performance.
      (3) Consider any additional information the board determines relevant to making the determination.
   c. If the board determines the carrier's performance under the existing contract does not meet the board's expectations or the proposed premium renewal amount exceeds the board's expectations and the board determines to solicit a bid under section 54-52.1-04, the board shall specify its reasons for the determination to solicit a bid.

54-52.1-05.1. Health insurance benefits coverage - Insured and provider data disclosure.

Except as necessary for treatment, payment, or health care operations, a carrier providing health insurance benefits coverage under this chapter may not disclose identifiable or unidentifiable insured or provider data or information to a related or unrelated health care delivery entity. The board may establish exceptions to the disclosure limitations under this section for the limited purpose of addressing public interest and benefit activities or for the limited purpose of addressing research, public health, or health care operations. An exception established by the board under this section may not be more permissive than allowed under state and federal privacy laws.

54-52.1-06. State contribution.

Each department, board, or agency shall pay to the board each month from its funds appropriated for payroll and salary amounts a state contribution in the amount as determined by the primary carrier of the group contract for the full single rate monthly premium for each of its eligible employees enrolled in the uniform group insurance program and the full rate monthly premium, in an amount equal to that contributed under the alternate family contract, including major medical coverage, for hospital and medical benefits coverage for spouses and dependent children of its eligible employees enrolled in the uniform group insurance program pursuant to section 54-52.1-07. The board shall then pay the necessary and proper premium amount for the uniform group insurance program to the proper carrier or carriers on a monthly basis. Any refund, rebate, dividend, experience rating allowance, discount, or other reduction of premium amount must be credited at least annually to a separate fund of the uniform group insurance program to be used by the board to reimburse the administrative expense and benefit fund of the public employees retirement program for the costs of administration of the uniform group insurance program. In the event an enrolled eligible employee is not entitled to receive salary, wages, or other compensation for a particular calendar month, that employee may make direct

payment of the required premium to the board to continue the employee's coverage, and the employing department, board, or agency shall provide for the giving of a timely notice to the employee of that person's right to make such payment at the time the right arises.

54-52.1-06.1. Uniform group insurance program benefits - Continuing appropriation.

The funds necessary to pay the consulting fees and health insurance benefits related to the uniform group insurance program are hereby appropriated from insurance premiums received by the board.

54-52.1-07. Optional coverage for employee's family.

Each eligible employee enrolled in the uniform group insurance program may elect to include that person's spouse and all qualified dependents, as provided for in the plan, within the hospital benefits coverage and medical benefits coverage, the state to pay the cost of such coverage as provided in section 54-52.1-06.

54-52.1-08. Administration - Board to promulgate rules and regulations.

It is the responsibility of the board to account for and disburse premium payments, maintain records, prepare reports, and to perform such other functions as may be necessary to carry out the provisions of this chapter. The board may promulgate such rules and regulations as may be necessary to carry out the provisions of this chapter.

54-52.1-08.1. Administrative - Nondiscrimination testing for health and life insurance programs.

The board shall be responsible for the nondiscrimination testing required under section 89 of the Internal Revenue Code. The board may engage the services of a consultant to assist the board in its administration of this section. The various state departments, boards, agencies, and commissions shall provide the board with requested information so the board may carry out its duties under this section.

54-52.1-08.2. Uniform group insurance program - Compliance with federal requirements - Group purchasing arrangements.

If the board determines that any section or the phraseology of any section of this chapter does not comply with applicable federal statutes or rules, the board shall adopt appropriate terminology with respect to that section to comply with the federal statutes or rules, subject to the approval of the legislative management's employee benefits programs committee. The board may assume responsibility for group purchasing arrangements as provided by federal law. Any plan modifications made by the board under this section are effective until the effective date of any measure enacted by the legislative assembly providing the necessary amendments to this chapter to ensure compliance with the federal statutes or rules.

54-52.1-09. Reports.

Each department, board, or agency shall keep such records, make such certifications, and furnish the board or carriers with such information and reports as may be necessary to enable the board or carriers to carry out their functions under the provisions of this chapter. Carriers that have entered into a contract with the board are required to furnish such reasonable reports as the board determines to be necessary, and to permit the board to examine those records that relate to the uniform group insurance program.

54-52.1-10. Exemption from state premium tax.

All premiums, consideration for annuities, policy fees, and membership fees collected under this chapter are exempt from the tax payable pursuant to section 26.1-03-17.

54-52.1-11. Confidentiality of employee records.

Information pertaining to an eligible employee's group medical records for claims, employee premium payments made, salary reduction amounts taken, history of any available insurance

coverage purchased, and amounts and types of insurance applied for under the supplemental life insurance coverage under this chapter is confidential and is not a public record. The information and records may be disclosed, under rules adopted by the board, only to:

1. A person to whom the eligible employee has given written authorization to have the information disclosed.
2. A person legally representing the eligible employee, upon proper proof of representation, and unless the eligible employee specifically withholds authorization.
3. A person authorized by a court order.
4. A person or entity to which the board is required to disclose information pursuant to federal or state statutes or regulations.
5. Any person or entity if the purpose of the disclosure is for treatment, payment, or health care operations.

54-52.1-12. Ownership and confidentiality of the uniform group health insurance medical records of employees, retirees, and dependents.

The medical records and related data of the employees, retirees, and dependents, obtained as the result of enrollment in the uniform group insurance program, are the property of the public employees retirement system. The records and data are confidential and are not public records. However, the board may allow administrators of administrative services only contracts or third-party administrators contracts access to the records and data where it is required in the performance of the administrator's duties pursuant to the contract. No administrator may be held liable for furnishing to the board information with respect to any patient, or any physician, hospital, or other health care provider.

54-52.1-13. Uniform prescription drug cards.

The board shall provide for issuance of uniform prescription drug cards under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 in the same manner as provided under section 26.1-36-43.

54-52.1-14. Wellness program.

The board shall develop an employer-based wellness program. The program must encourage employers to adopt a board-developed wellness program by either charging extra health insurance premium to nonparticipating employers or reducing premium for participating employers.

54-52.1-15. Acceptance and expenditure of third-party payments - Continuing appropriation.

The board may receive moneys from third parties, including the federal government, pursuant to one or more federal programs. Any money received from a third party by the board is appropriated to the board on a continuing basis for the board's use in paying benefits, premiums, or administrative expenses under the uniform group insurance program.

54-52.1-16. Uniform group insurance program - Collaborative drug therapy program - Continuing appropriation.

1. The board may establish a collaborative drug therapy program available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals in identified health populations and to manage health care expenditures.
2. Under the program, the board may involve physicians, pharmacists, and other health professionals to coordinate health care for individuals in identified health populations in order to improve health outcomes and reduce spending on care for the identified health problem. Under the program, pharmacists and other health professionals may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals in the identified health population. To encourage enrollment in the plan, the board may provide incentives to covered individuals in the identified health

population which may include waived or reduced copayment for related treatment drugs and supplies.

3. The board may request the assistance of the North Dakota pharmacists association or a specified delegate to implement a formalized disease management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize chronic disease care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.
4. The board may seek and accept private contributions, gifts, and grants-in-aid from the federal government, private industry, and other sources for a collaborative drug therapy program for identified health populations. Any funds that may become available through contributions, gifts, grants-in-aid, or other sources to the board for a collaborative drug therapy program are appropriated to the board on a continuing basis.

54-52.1-17. Uniform group insurance program - Collaborative drug therapy program - Funding.

1. The board shall establish a collaborative drug therapy program that is to be available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals with diabetes and to manage health care expenditures.
2. The board shall involve physicians, pharmacists, and certified diabetes educators to coordinate health care for covered individuals with diabetes in order to improve health outcomes and reduce spending on diabetes care. Under the program, pharmacists and certified diabetes educators may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals with diabetes. To encourage enrollment in the plan, the board shall provide incentives to covered individuals who have diabetes which may include waived or reduced copayment for diabetes treatment drugs and supplies.
3. The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize diabetes care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of diabetes care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.
4. The board shall fund the program from any available funds in the uniform group insurance program and if necessary the fund may add up to a two dollar per month charge on the policy premium for medical and hospital benefits coverage. A state agency shall pay any additional premium from the agency's existing appropriation.

54-52.1-18. High-deductible health plan alternative with health savings account option.

1. The board shall develop and implement a high-deductible health plan as an alternative to the plan under section 54-52.1-02. The high-deductible health plan alternative with a health savings account must be made available to state employees by January 1, 2012. After June 30, 2015, at the board's discretion, the high-deductible health plan alternative may be offered to political subdivisions for coverage of political subdivision employees. If a political subdivision elects this high-deductible option the political subdivision may not offer the plan under section 54-52.1-02.
2. Health savings account fees for participating state employees must be paid by the employer.
   a. Except as provided in subdivision b, subject to the limits of section 223(b) of the Internal Revenue Code [26 U.S.C. 233(b)], the difference between the cost of the single and family premium for eligible state employees under section 54-52.1-06

and the premium for those employees electing to participate under the high-deductible health plan under this section must be deposited in a health savings account for the benefit of each participating employee.

b. If the public employees retirement system is unable to establish a health savings account due to the employee's ineligibility under federal or state law or due to failure of the employee to provide necessary information in order to establish the account, the system is not responsible for depositing the health savings account contribution. The member will remain a participant in the high-deductible health plan regardless of whether a health savings account is established.

3. Each new state employee must be provided the opportunity to elect the high-deductible health plan alternative. At least once each biennium, the board shall provide an open enrollment period allowing existing state employees or a political subdivision to change their coverage.