

CHAPTER 26.1-18.1
HEALTH MAINTENANCE ORGANIZATIONS

26.1-18.1-01. Definitions.

1. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, and diagnostic and therapeutic radiological services.
2. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
3. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.
4. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.
5. "Deductible" means the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment.
6. "Enrollee" means an individual who is covered by a health maintenance organization.
7. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contractholder.
8. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.
9. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.
10. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.
11. "Group contractholder" means the person to which a group contract has been issued.
12. "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both. However, a qualified program of all-inclusive care for the elderly is not a health maintenance organization.
13. "Health maintenance organization producer" means an insurance producer, as defined in section 26.1-26-02, who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise holds out to the public as such.
14. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.
15. "Insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
16. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.
17. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities do not include fully subordinated debt.
18. "Participating provider" means a provider as defined in subsection 19 who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees

- with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.
19. "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.
 20. "Qualified program of all-inclusive care for the elderly" means a program that:
 - a. Is sponsored by a religious or charitable organization that is itself or is controlled by an entity organized under section 501(c)(3) of the Internal Revenue Code [26 U.S.C. 501(c)(3)];
 - b. Has been approved by the centers for Medicare and Medicaid services of the United States department of health and human services to operate, and is currently operating as, a program of all-inclusive care for the elderly; and
 - c. Has revenues from private pay sources which do not exceed ten percent of the program's total revenues.
 21. "Replacement coverage" means the benefits provided by a succeeding carrier.
 22. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.
 23. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

26.1-18.1-02. Establishment of health maintenance organizations.

1. Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person may establish or operate a health maintenance organization in this state without obtaining a certificate of authority under this chapter. A foreign corporation may qualify under this chapter, subject to obtaining a certificate of authority as a foreign corporation under section 10-19.1-136 and compliance with all provisions of this chapter and other applicable state laws.
2. Any health maintenance organization that has not previously received a certificate of authority to operate as a health maintenance organization as of August 1, 1993, shall submit an application for a certificate of authority under subsection 3 within thirty days of August 1, 1993. Each applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied under section 26.1-18.1-03, the applicant must thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.
3. Each application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be in a form prescribed by the commissioner, and must set forth or be accompanied by the following:
 - a. A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto.
 - b. A copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant.
 - c. A list of the names, addresses, and official positions and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association.

- d. A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third-party administrators, marketing consultants, or persons listed in subdivision c and the health maintenance organization.
 - e. A copy of the form of evidence of coverage to be issued to the enrollees.
 - f. A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations.
 - g. Financial statements showing the applicant's assets, liabilities, and sources of financial support, including both a copy of the applicant's most recent and regular certified financial statement and an unaudited current financial statement.
 - h. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding.
 - i. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.
 - j. A statement or map reasonably describing the geographic area or areas to be served.
 - k. A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances.
 - l. A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and re-evaluation when deficiencies in provider or organizational performance are identified.
 - m. A description of the procedures to be implemented to meet the protection against insolvency requirements in section 26.1-18.1-12.
 - n. A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements.
 - o. Such other information as the commissioner may require to make the determinations required in section 26.1-18.1-03.
4. a. The commissioner may adopt rules as the commissioner deems necessary to the proper administration of this chapter to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modifications, or amendments to the items described in subsection 3 to the commissioner, either for the commissioner's approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next succeeding site visit or examination.
- b. Any modification or amendment for which the commissioner's approval is required is deemed approved unless disapproved within thirty days, provided that the commissioner may postpone the action for such further time, not exceeding an additional thirty days, as necessary for proper consideration.

26.1-18.1-03. Issuance of certificate of authority.

1. Upon receipt of an application for issuance of a certificate of authority, the commissioner shall issue a certificate of authority to any person filing a completed

application upon receiving the prescribed fees and upon the commissioner being satisfied that:

- a. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.
 - b. The health maintenance organization's proposed plan of operation meets the requirements of section 26.1-18.1-06.
 - c. The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles.
 - d. The health maintenance organization is in compliance with sections 26.1-18.1-12 and 26.1-18.1-14.
2. A certificate of authority may be denied only after the commissioner complies with the requirements of section 26.1-18.1-19.

26.1-18.1-03.1. Bond or insurance requirement.

A qualified program of all-inclusive care for the elderly that operates in this state shall maintain a surety bond, in the amount of two hundred fifty thousand dollars. Any surety bond issued under this section must authorize recovery by the commissioner on behalf of any person in this state that sustained damages as the result of unfair practices, conviction of fraud, or failure by a qualified program of all-inclusive care for the elderly to perform a contractual obligation owed to the person.

26.1-18.1-04. Powers of health maintenance organizations.

1. The powers of a health maintenance organization include the following:
 - a. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization.
 - b. Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts between affiliates or between the health maintenance organization and its parent.
 - c. The furnishing of health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization.
 - d. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration.
 - e. The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.
 - f. The offering of other health care services, in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual.
 - g. The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.
2. a. A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subdivisions a, b, and d of subsection 1 which may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the exercise of power only if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations.

- b. The commissioner may adopt rules exempting from the filing requirement of subdivision a those activities having a de minimis effect.

26.1-18.1-05. Fiduciary responsibilities.

1. Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization is responsible for the funds in a fiduciary relationship to the organization.
2. If the commissioner deems it necessary for the security of the funds of a health maintenance organization, the commissioner may require an official bond of each officer and each employee of the organization in an amount not to exceed the sum of money for which each is accountable.

26.1-18.1-06. Quality assurance program.

1. The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees will be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures must include mechanisms to assure availability, accessibility, and continuity of care.
2. The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program must include, at a minimum, the following:
 - a. A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees.
 - b. A written quality assurance plan which describes the following:
 - (1) The health maintenance organization's scope and purpose in quality assurance.
 - (2) The organizational structure responsible for quality assurance activities.
 - (3) Contractual arrangements, when appropriate, for delegation of quality assurance activities.
 - (4) Confidentiality policies and procedures.
 - (5) A system of ongoing evaluation activities.
 - (6) A system of focused evaluation activities.
 - (7) A system for credentialing providers and performing peer review activities.
 - (8) Duties and responsibilities of the designated physician responsible for the quality assurance activities.
 - c. A written statement describing the system of ongoing quality assurance activities, including:
 - (1) Problem assessment, identification, selection, and study.
 - (2) Corrective action, monitoring, evaluation, and reassessment.
 - (3) Interpretation and analysis of patterns of care rendered to individual patients by individual providers.
 - d. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format.
 - e. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.
3. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the commissioner.
4. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination

- of patient care and assessing the quality of health and medical care provided to enrollees.
5. Enrollee clinical records must be available to the commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the commissioner. The clinical records are confidential and are not subject to section 44-04-18, except upon written consent for disclosure by the enrollee or the enrollee's authorized representative.
 6. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate organization staff.

26.1-18.1-07. Requirements for group contract, individual contract, and evidence of coverage.

1. a. Every group and individual contractholder is entitled to a group or individual contract.
b. The contract may not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by chapter 26.1-04.
c. The contract must contain a clear statement of the following:
 - (1) Name and address of the health maintenance organization.
 - (2) Eligibility requirements.
 - (3) Benefits and services within the service area.
 - (4) Emergency care benefits and services.
 - (5) Out-of-area benefits and services, if any.
 - (6) Copayments, deductibles, or other out-of-pocket expenses.
 - (7) Limitations and exclusions.
 - (8) Enrollee termination.
 - (9) Enrollee reinstatement, if any.
 - (10) Claims procedures.
 - (11) Enrollee grievance procedures.
 - (12) Continuation of coverage.
 - (13) Conversion.
 - (14) Extension of benefits, if any.
 - (15) Coordination of benefits, if applicable.
 - (16) Subrogation, if any.
 - (17) Description of the service area.
 - (18) Entire contract provision.
 - (19) Term of coverage.
 - (20) Cancellation of group or individual contractholder.
 - (21) Renewal.
 - (22) Reinstatement of group or individual contractholder, if any.
 - (23) Grace period.
 - (24) Conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in this subdivision.
2. In addition to those provisions required in subdivision c of subsection 1, an individual contract must provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, the person must pay for the services.
3. a. Every subscriber shall receive an evidence of coverage from the group contractholder or the health maintenance organization.
b. The evidence of coverage may not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by chapter 26.1-04.

- c. The evidence of coverage must contain a clear statement of the provisions required in subdivision c of subsection 1.
4. The commissioner may adopt rules establishing readability standards for individual contract, group contract, and evidence of coverage forms.
5. No group or individual contract, evidence of coverage, or amendment thereto may be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner, as provided by sections 26.1-30-19 and 26.1-30-20.
6. The provisions set forth in sections 26.1-30-20 and 26.1-30-21 govern the approval and disapproval of forms required to be filed under this section.
7. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

26.1-18.1-08. Annual report.

1. Every domestic health maintenance organization shall annually, on or before March first, and every foreign health maintenance organization shall annually, on or before the date that its annual report is due in its domestic state, file a report verified by at least two principal officers with the commissioner, covering the preceding calendar year. The report must be on forms prescribed by the commissioner. In addition, the domestic health maintenance organization shall file by March first, and every foreign health maintenance organization shall file annually, on or before the date that its annual report is due in its domestic state, unless otherwise stated:
 - a. Audited financial statements on or before June first.
 - b. A list of the providers who have executed a contract that complies with subdivision a of subsection 4 of section 26.1-18.1-12.
 - c. (1) A description of the grievance procedures.
(2) The total number of grievances handled through the procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.
2. The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter. The commissioner may waive the filing of the annual report and other information for a health maintenance organization that has discontinued its operation in this state.
3. The commissioner may designate the national association of insurance commissioners as the repository for the filing of the annual report.

26.1-18.1-09. Information to enrollees or subscribers.

1. The health maintenance organization shall provide to its subscribers a list of providers upon enrollment and re-enrollment.
2. Every health maintenance organization shall provide within thirty days to its subscribers notice of any material change in the operation of the organization that will affect them directly.
3. An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.
4. The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained, and a telephone number where the enrollee can contact the health maintenance organization, at no cost to the enrollee.

26.1-18.1-10. Grievance procedures.

1. Every health maintenance organization shall establish and maintain a grievance procedure which has been approved by the commissioner to provide procedures for

the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of the grievances.

2. The commissioner may examine the grievance procedures.

26.1-18.1-11. Investments.

With the exception of investments made in accordance with subdivision a of subsection 1 of section 26.1-18.1-04, the funds of a health maintenance organization may be invested only in those investments authorized to be made by domestic insurance companies of this state.

26.1-18.1-12. Protection against insolvency.

1. Net worth requirements.
 - a. Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under subdivision b.
 - b. Except as provided in subdivisions c and d, every health maintenance organization must maintain a minimum net worth equal to the greater of:
 - (1) One million dollars;
 - (2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars;
 - (3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or
 - (4) An amount equal to the sum of:
 - (a) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and
 - (b) Four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.
 - c. A health maintenance organization licensed before August 1, 1993, and licensed only in this state must maintain the minimum requirements which are in effect at the time this chapter became law.
 - d.
 - (1) In determining net worth, no debt may be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.
 - (2) The interest expenses relating to the repayment of any fully subordinated debt must be considered covered expenses.
 - (3) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, may not be considered a liability and must be recorded as equity.
2. Deposit requirements.
 - a. Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than three hundred thousand dollars.
 - b. A health maintenance organization that is licensed only in this state and is in operation on August 1, 1993, shall make a deposit equal to one hundred thousand dollars.
 - c. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

- d. All income from deposits is an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities must be approved by the commissioner before being deposited or substituted.
 - e. The deposit must be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit is an asset subject to the provisions of the liquidation act.
 - f. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to the effect, duly authenticated by the appropriate state official holding the deposit.
3. Liabilities. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims. The liabilities must be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.
 4. Hold harmless.
 - a. Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee is not liable to the provider for any sums owed by the health maintenance organization.
 - b. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.
 - c. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.
 5. Continuation of benefits. The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering a plan, the commissioner may require:
 - a. Insurance to cover the expenses to be paid for continued benefits after an insolvency.
 - b. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollee's discharge from inpatient facilities.
 - c. Insolvency reserves.
 - d. Acceptable letters of credit.

- e. Any other arrangements to assure that benefits are continued as specified above.
6. Notice of termination. An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the organization at least sixty days' advance notice of termination.

26.1-18.1-13. Uncovered expenditures insolvency deposit.

1. If at any time uncovered expenditures exceed ten percent of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit must at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and must be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.
2. The deposit required under this section is in addition to the deposit required under section 26.1-18.1-12 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from the deposits or trust accounts is an asset of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.
3. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if a substitute deposit of cash or securities of equal amount and value is made, the fair market value exceeds the amount of the required deposit, or the required deposit under subsection 1 is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.
4. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures must be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining must be paid into the liquidation or receivership of the health maintenance organization.
5. The commissioner may by regulation prescribe the time, manner, and form for filing claims under subsection 4.
6. The commissioner may by rule or order require health maintenance organizations to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

26.1-18.1-14. Enrollment period and replacement coverage in the event of insolvency.

1. Enrollment period.
 - a. In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

- b. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for the groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.
 - c. The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.
2. Replacement coverage.
- a. "Discontinuance" means the termination of the contract between the group contractholder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.
 - b. Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.
 - c. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits pre-existed the effective date of the succeeding carrier's contract may be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

26.1-18.1-15. Filing requirements for rating information.

- 1. No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

2. Either a specific schedule of premium rates, or a methodology for determining premium rates, must be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee may not be individually determined based on the status of the enrollee's health. However, the premium rates may not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.
3. The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection 2 are met. The procedures set forth in sections 26.1-30-20 and 26.1-30-21 govern the approval and disapproval of rating information required to be filed under this section.

26.1-18.1-16. Regulation of health maintenance organization producers.

1. The commissioner may adopt rules necessary to provide for the licensing of health maintenance organization producers. The rules must establish:
 - a. The requirements for licensure of resident health maintenance organization producers.
 - b. The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers.
 - c. Any examination, prelicensing, or continuing education requirements.
 - d. The requirements for registering and terminating the appointment of health maintenance organization producers.
 - e. Any requirements for registering any assumed names or office locations in which a health maintenance organization producer does business.
 - f. The conditions for health maintenance organization producer license renewal.
 - g. The grounds for denial, refusal, suspension, or revocation of a health maintenance organization producer's license.
 - h. Any required fees for the licensing activities of health maintenance organization producers.
 - i. Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.
2. None of the following may be required to hold a health maintenance organization producer license:
 - a. Any regular salaried officer or employee of a health maintenance organization who devotes substantially all of the person's time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;
 - b. Employers or their officers or employees or the trustees of any employee benefit plan to the extent that the employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships, provided that the employers, officers, employees, or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing the health maintenance organization memberships;
 - c. Banks or their officers and employees to the extent that the banks, officers, and employees collect and remit charges by charging same against accounts of depositors on the orders of the depositor; or
 - d. Any person or the employee of any person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by the payment of an

amount calculated as a percentage of the revenues, net income, or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this chapter.

3. The commissioner may by rule exempt certain classes of persons from the requirement of obtaining a license:
 - a. If the functions they perform do not require special competence, trustworthiness, or the regulatory surveillance made possible by licensing; or
 - b. If other existing safeguards make regulation unnecessary.

26.1-18.1-17. Powers of insurers.

1. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law which may be inconsistent, any two or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.
2. Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under the laws. Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

26.1-18.1-18. Examinations.

1. The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five years.
2. Every health maintenance organization and provider shall submit its books and records for the examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and insurance producers of, the health maintenance organization and the principals of the providers concerning their business.
3. The expenses of examinations under this section must be assessed against the health maintenance organization being examined and remitted to the commissioner.
4. In lieu of the examination, the commissioner may accept the report of an examination made by the commissioner of another state.

26.1-18.1-19. Suspension or revocation of certificate of authority.

1. Any certificate of authority issued under this chapter may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner finds that any of these conditions exist:
 - a. The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section 26.1-18.1-02, unless amendments to the submissions have been filed with and approved by the commissioner.
 - b. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of sections 26.1-18.1-07 and 26.1-18.1-15.

- c. The health maintenance organization does not provide or arrange for basic health care services.
 - d. (1) The health maintenance organization does not meet the requirements of section 26.1-18.1-06; or
(2) The health maintenance organization is unable to fulfill its obligations to furnish health care services.
 - e. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
 - f. The health maintenance organization has failed to correct, within the time prescribed by subsection 3, any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired.
 - g. The health maintenance organization has failed to implement the grievance procedures required by section 26.1-18.1-10 in a reasonable manner to resolve valid complaints.
 - h. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.
 - i. The continued operation of the health maintenance organization would be hazardous to its enrollees.
 - j. The health maintenance organization has otherwise failed substantially to comply with this chapter.
2. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to ten thousand dollars for each cause for suspension or revocation.
 3. The following pertains when insufficient net worth is maintained:
 - a. Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this chapter is less than the minimum net worth required to be maintained by section 26.1-18.1-12, the commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require filing with the commissioner a plan for correction of the deficiency acceptable to the commissioner, and correction of the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the commissioner. Such a deficiency must be deemed an impairment, and failure to correct the impairment in the prescribed time is grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation, or liquidation.
 - b. Unless allowed by the commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing the coverage is impaired, and the fact of the impairment is known to the health maintenance organization or to the person. However, the existence of an impairment does not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.
 4. A certificate of authority must be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.
 - a. Suspension or revocation of a certificate of authority or the denial of an application or the imposition of an administrative penalty pursuant to this section must be by written order and must be sent to the health maintenance organization or applicant by certified mail. The written order must state the grounds, charges, or conduct on which suspension, revocation, or denial or

administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty days from the date of mailing of the order. If no written request is made, the order is final upon the expiration of said thirty days.

- b. If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:
 - (1) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and
 - (2) A specific place for the hearing, which may be either in Bismarck, North Dakota, or in the county where the health maintenance organization's or applicant's principal place of business is located.

After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the commissioner shall take whatever action the commissioner deems necessary based on written findings and shall mail the decision to the health maintenance organization or applicant. The action of the commissioner is subject to review under chapter 28-32, or other applicable statutory review process.

5. The provisions of chapter 28-32 apply to proceedings under this section to the extent they are not in conflict with subdivision b of subsection 4.
6. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and may not engage in any advertising or solicitation whatsoever.
7. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It may engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

26.1-18.1-20. Rehabilitation, liquidation, or conservation of health maintenance organizations.

1. Any rehabilitation, liquidation, or conservation of a health maintenance organization must be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in chapter 26.1-06; or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.
2. For purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries have the same priority as established by chapter 26.1-06.1 for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability has the status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan has a priority of distribution of the general assets immediately

following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in chapter 26.1-06.1.

26.1-18.1-21. Summary orders and supervision.

1. Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this chapter, the commissioner may, after notice and hearing, order the health maintenance organization to take action as may be reasonably necessary to rectify the condition or violation, including one or more of the following:
 - a. Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner.
 - b. Reduce the volume of new business being accepted.
 - c. Reduce expenses by specified methods.
 - d. Suspend or limit the writing of new business for a period of time.
 - e. Increase the health maintenance organization's capital and surplus by contribution.
 - f. Take other steps as the commissioner may deem appropriate under the circumstances.
2. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject must be deemed a violation of this chapter.
3. The commissioner may set uniform standards and criteria by rule for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards must be consistent with the purposes expressed in subsection 1.
4. The remedies and measures available to the commissioner under this section are in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of section 26.1-06.1-09.

26.1-18.1-22. Rulemaking authority.

The commissioner may adopt reasonable rules necessary and proper to carry out the provisions of this chapter.

26.1-18.1-23. Confidentiality of medical information and limitation of liability.

1. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization must be held in confidence and may not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, or upon the express consent of the enrollee or applicant, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against the disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.
2. A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee or who furnishes any records, information, or assistance to such a committee is not subject to liability for civil damages or any legal action in consequence of the action, nor is the health maintenance organization which established the committee or the officers, directors, employees, or agents of the health maintenance organization liable for the activities of any person. This section may not be construed to relieve any person of liability arising from treatment of a patient.

3. a. The information considered by a health care review committee and the records of their actions and proceedings are confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director, or other member of a health maintenance organization or its staff engaged in assisting the committee, or any person assisting or furnishing information to the committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on the activities.
- b. Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subdivision a by a state licensing or certifying agency or in an appeal must be kept confidential and is subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.
4. To fulfill its obligations under section 26.1-18.1-06, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any enrollee.

26.1-18.1-24. Acquisition of control of or merger of a health maintenance organization.

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization information required by section 26.1-10-03 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner. Approval by the commissioner must be governed by section 26.1-10-03.

26.1-18.1-25. Coordination of benefits.

1. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.
2. If health maintenance organizations adopt coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans.
3. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are received from nonparticipating providers, provided outside their service areas, or not covered under the terms of their group contracts or evidence of coverage.