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 health 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 health 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. The term 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 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 insurance benefits coverage" means hospital benefits coverage or medical benefits coverage, or both.
6. "Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter 26.1-18.1.
7. "Hospital benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for hospital services incurred in accordance with the uniform contract.
8. "Life insurance benefits coverage" means a plan that 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.
9. "Medical benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for medical services in accordance with the uniform contract.
10. "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.
11. "Member's account balance" means the member's contributions plus interest at the rate set by the board.

12. "Self-insurance health plan" means a plan of self-insurance providing health insurance benefits coverage under section 54-52.1-04.2.
13. "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 July 1, 2015, 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 July 1, 2015, 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. 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 patrol troopers' 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.

3. Upon the termination of employment when the employee is not eligible to participate under subsection 2 or 4 or applicable federal law, that employee cannot continue as a member of the uniform group.
4. A member or former member of the legislative assembly or that individual'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 individual's surviving spouse shall pay the premiums in effect for the coverage provided directly to the board.
5. Each eligible employee requesting enrollment shall furnish the appropriate individual 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.
6. 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. a. 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, 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.
   b. 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 patrol troopers' 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.
   c. 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:
      (1) Members first enrolled after December 31, 2019, for which a governmental unit contributes to the public employees retirement system fund under section 54-52-06 or the retirement plan under chapter 54-52.6; and
      (2) 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.
   d. 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.
   e. 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.

f. 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.

g. 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.

h. The board, as trustee of the fund and in exclusive control of its administration, shall:

(1) 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.

(2) 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 for any dental, vision, and long-term care benefits coverage under any 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 before 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 individuals are entitled to receive credit for hospital benefits coverage, medical benefits coverage, and prescription drug coverage under any health insurance program and for any dental, vision, and long-term care benefits coverage under any insurance program:

a. A member or surviving spouse of the highway patrol troopers' retirement system is eligible for the credit beginning on the date retirement benefits are effective.

b. If the member first enrolled before January 1, 2020, a member or surviving spouse of the public employees retirement system is eligible for the credit beginning on the date retirement benefits are effective.

c. A member or surviving spouse of the retirement program established by job service North Dakota under section 52-11-01 is eligible for the credit beginning on the date retirement benefits are effective.

d. A retired judge or surviving spouse of the retirement program established under chapter 27-17 is eligible for the credit beginning on the date retirement benefits are effective.

e. If the former participating member first enrolled before January 1, 2020, 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 the board's rules.

2. The board shall calculate the allowable monthly credit toward hospital benefits coverage, medical benefits coverage, and prescription drug coverage under any health insurance program and toward dental, vision, and long-term care benefits coverage under any insurance program 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 patrol troopers' 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 before attaining the age of sixty-five and an additional reduction factor of six percent applies for each year the member terminates employment before attaining the age of sixty-four. For a member of the highway patrol troopers' 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 before attaining the age of fifty-five and an additional reduction factor of six percent applies for each year the member terminates employment before 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 before attaining the age of sixty-five and an additional reduction factor of six percent applies for each year the member terminates employment before 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 individual eligible under subsection 1 for hospital benefits coverage, medical benefits coverage, and prescription drug coverage under any health insurance program and for dental, vision, and long-term care benefits coverage under any insurance program. The board shall allow spouses who each have credit under subsection 2 to combine the spouses' 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. As an alternative to the calculation of the allowable monthly credit under subsection 2, the board may 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.

54-52.1-03.5. Emergency responders who die in the line of duty - Health benefits. (Retroactive application - See note)

1. As used in this section:
   a. "Correctional facility staff" has the same meaning as provided under section 12-44.1-01.
   b. "Dies in the line of duty" means a death occurring as a direct and proximate result of a personal injury sustained by an emergency responder while engaged in a line of duty activity or which arose out of and as a result of the individual's performance of a line of duty activity.
   c. "Emergency responder" means a peace officer, member of a correctional facility staff, emergency medical services personnel, or firefighter, who is employed by the state, a political subdivision of the state, or an institution under the control of the state board of higher education. The term does not include a national guard security officer or national guard firefighter.
   d. "Line of duty activity" means an employment-related action taken by an emergency responder which is required or authorized by law, rule, regulation, or condition of employment and for which compensation is provided by the employing entity or would have been eligible to have been provided by the employing entity if the emergency responder had been on duty at the time the action in question was taken.
   e. "Peace officer" has the same meaning as provided under section 12-63-01. The term includes a game warden.
2. At no charge, the board shall offer health insurance benefits coverage, including drug benefits coverage, to the surviving spouse and dependent child of an emergency responder who dies in the line of duty. The provision of health insurance benefits coverage under this section includes coverage of a child of the emergency responder who is born within ten months of the date of the death.
3. The provision of health insurance benefits coverage under this section must continue for the:
   a. Surviving spouse until the surviving spouse reaches age sixty-five; and
   b. Dependent child until the dependent child reaches age twenty-six.
4. An employer shall notify the board of the qualifying event of an emergency responder dying in the line of duty.
5. This section does not affect eligibility for benefits under title 65.

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

1. 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 all or part of the prescription drug benefits coverage component of medical benefits coverage; and shall accept one or more bids of and contract with the carriers the board determines best serve the interests of the state and the state's 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 which 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:

a. The economy to be effected.
b. The ease of administration.
c. The adequacy of the coverages.
d. The financial position of the carrier, with special emphasis on the solvency of the carrier.
e. The reputation of the carrier and any other information available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

2. The board may reject any or all bids received under this section. If the board rejects all bids received, the board shall again solicit bids as provided in this section.
3. Under sections 54-52.1-04.1 and 54-52.1-04.2 the board may contract for health benefits coverage through a health maintenance organization or establish a self-insurance health plan.

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 health plan.

1. This section applies to a self-insurance health plan for:
   a. Health insurance and prescription drug benefits coverage;
   b. Health insurance benefits coverage, excluding all or part of prescription drug benefits coverage; or
   c. All or part of prescription drug benefits coverage.
2. Except for prescription drug coverage under subdivision c of subsection 1, a self-insurance health plan established by the board 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. The board may not establish a self-insurance health plan unless the board determines the self-insurance health plan best serves the interests of the state and the state's eligible employees. If the board determines it is in the best interest of the plan, individual stop-loss coverage insured by a carrier authorized to do business in this state may be made part of a self-insurance health plan.

54-52.1-04.3. Self-insurance health plan - Reserve fund - Continuing appropriation - Benefits - Insurance commissioner.

1. Pursuant to chapter 26.1-36.6, the board shall establish and maintain under a self-insurance health plan a reserve fund to provide for adverse fluctuations in future charges, claims, costs, or expenses of the uniform group insurance program. Upon the initial changeover from a contract for insurance pursuant to section 54-52.1-04 or a health maintenance organization pursuant to section 54-52.1-04.1 to a self-insurance health plan pursuant to section 54-52.1-04.2, the board must have a plan in place which is reasonably calculated to meet within sixty months of the changeover the funding requirements of chapter 26.1-36.6. All moneys in the reserve fund, not otherwise appropriated, are appropriated to the board for the payment of claims and other costs of the uniform group insurance program during periods of adverse claims or cost fluctuations.

2. A self-insurance health plan must comply with section 26.1-36.6-03 and must provide the same benefits required of a fully insured plan.
3. The insurance commissioner shall ensure compliance with and enforce the provisions of this section pursuant to chapter 26.1-36.6.

54-52.1-04.4. Insurance to cover mammogram examinations.
Repealed by S.L. 2019, ch. 462, § 10.

54-52.1-04.5. Insurance to cover involuntary complications of pregnancy.
Repealed by S.L. 2019, ch. 462, § 10.

54-52.1-04.6. Coverage for treatment of certain disorders.
Repealed by S.L. 2019, ch. 462, § 10.

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.
Repealed by S.L. 2019, ch. 462, § 10.

54-52.1-04.11. Insurance to cover foods and food products for inherited metabolic diseases.
Repealed by S.L. 2019, ch. 462, § 10.

54-52.1-04.12. Insurance to cover medical services related to intoxication.
Repealed by S.L. 2019, ch. 462, § 10.

54-52.1-04.13. Coverage of telehealth services.
Repealed by S.L. 2019, ch. 462, § 10.

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

Repealed by S.L. 2019, ch. 462, § 10.

54-52.1-04.15. Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

1. If the prescription drug coverage component of a health insurance benefits coverage contract received in response to a request for bids under section 54-52.1-04 utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, in addition to the factors set forth under section 54-52.1-04 the board shall consider and give preference to an insurer's contract that:
   a. Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefits management company which controls the prescriptions drug coverage offered as part of the health insurance benefits coverage, and if the contract is revised or a new contract is entered, requires the insurer to provide the board with the revision or new contract within thirty days of the change.
   b. Provides the board with monthly claims data and information on all programs being implemented or modified, including prior authorization, step therapy, mandatory use of generic drugs, or quantity limits.
   c. Describes the extent to which the board may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are covered; the formulary; and the member programs implemented.
   d. Describes the audit rights of the board.
2. The board may conduct annual audits to the extent permitted under the contract terms agreed to under subsection 1. The audits must include:
   a. A review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.
   b. A review of a list of all programs that have been implemented or modified during the audit period under subsection 1, and in connection with each program the auditor shall report on the cost, the cost savings or avoidance, member disruption, the process for and number of overrides or approvals and disapprovals, and clinical outcomes.
   c. Recommendations for proposed changes to the prescription drug benefit programs to decrease costs and improve plan beneficiaries' health care treatment.
3. Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts.
4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager; a pharmaceutical manufacturer representative; or any retail, mail, or specialty drug pharmacy representative or vendor.

54-52.1-04.16. Prescription drug coverage - Performance audits.

1. Except for Medicare part D, prescription drug coverage, the board may not enter or renew a contract for prescription drug coverage unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services. The contract must provide:
   a. The board must have full access to data regarding:
      (1) The total dollars paid to the pharmacy benefits manager by the carrier and the board;
      (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier which were not subsequently paid to a licensed pharmacy in the state; and

(3) Payments made to all pharmacy providers.

b. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated.

c. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated.

e. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. The contract must provide that all drug rebates, financial incentives, fees, and discounts must be disclosed to the board.

2. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board. The board's auditor, the insurance department, and the employee benefits programs committee may access any information the board may access under this section. All information accessed by the board, board's auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This subsection does not limit the information required to be disclosed to the board under subsection 1.

3. Except for Medicare part D, if the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.

4. Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to.

54-52.1-04.17. Self-insurance health plan - Bank of North Dakota line of credit - Continuing appropriation.

The Bank of North Dakota shall extend to the board a line of credit not to exceed fifty million dollars. The board shall repay the line of credit from health insurance premium revenue or repay the line of credit from other funds appropriated by the legislative assembly. The board may access the line of credit to the extent necessary to provide adequate claims payment funds, to purchase stop-loss coverage, and to defray other expenditures of administration of the self-insurance health plan. All loan funds received by the board from the Bank under this section, not otherwise appropriated, are appropriated to the board for the repayment of claims and other costs of the uniform group insurance program.

54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. (Expired effective July 31, 2025)

1. As used in this section:

a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:

(1) Rapid-acting insulin;

(2) Short-acting insulin;

(3) Intermediate-acting insulin;

(4) Long-acting insulin;

(5) Premixed insulin product;
(6) Premixed insulin/GLP-1 RA product; and
(7) Concentrated human regular insulin.

b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:
(1) Blood glucose meters;
(2) Blood glucose test strips;
(3) Lancing devices and lancets;
(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;
(5) Glucagon, in injectable and nasal forms;
(6) Insulin pen needles; and
(7) Insulin syringes.

c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.

2. The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration which complies with this section.
3. The coverage must limit out-of-pocket costs for a thirty-day supply of:
a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.
b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.
4. The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.
5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.
6. Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.
7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.
8. This section does not apply to the Medicare part D prescription drug coverage plan.

54-52.1-04.19. Uniform group insurance program - Prosthetic devices.

The board shall provide health insurance 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 prosthetic appliances and limbs. This coverage must include repair or replacement of a prosthetic limb or socket if medically appropriate.

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 uniform group insurance contract through a contract for insurance, health maintenance organization, or self-insurance health plan for hospital benefits coverage, medical benefits coverage, or prescription drug benefits 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, the proposed premium renewal amount does not exceed the board's expectations, and renewal best serves the interests of the state and the state's eligible employees.
   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. The board may determine the carrier's performance under the existing contract does not meet the board's expectations, the proposed premium renewal amount exceeds the board's expectations, or renewal does not best serve the interests of the state or the state's eligible employees and the board therefore may decide to solicit a bid under section 54-52.1-04.

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; for the limited purpose of addressing research, public health, or health care operations; or for the solicitation of bids pursuant to section 54-52.1-04. 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 - Penalty.

1. 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 then shall pay the necessary and proper premium amount for the uniform group insurance program to the proper carrier or carriers on a monthly basis.

2. 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.
3. If 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 employee's right to make such payment at the time the right arises.
4. A governmental unit that fails to pay the contributions by the board's established due date is subject to a civil penalty of fifty dollars and, as interest, one percent of the amount due for each month of delay or fraction of a month after the payment became due.

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.

54-52.1-09.1. Health insurance utilization reports.

Upon request by a political subdivision that receives benefits under the uniform group insurance program, the board shall provide that political subdivision with a health insurance utilization report that is substantively the same as a report required under subsection 1 of section 26.1-36.4-09. The board shall provide the report in a manner that is in compliance with the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

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.

In addition to the confidentiality requirements in section 26.1-36-12.4, 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 which 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 to which the board is required to disclose information pursuant to federal or state statutes or regulations.
5. Any person 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. 223(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.
   c. If a member closes the health savings account established for that member under this section, the system is not responsible for depositing the health savings account contribution after that closure.
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.