LETTER OPINION
93-L-342

November 30, 1993

The Honorable Glenn Pomeroy
Commissioner of Insurance
600 East Boulevard
Bismarck, ND 58505-0320

Dear Mr. Pomeroy:

Thank you for your November 4, 1993, letter asking whether the benefit plan committee is required to recommend one basic plan and one standard plan, each of which must meet federal health maintenance organization (HMO) guidelines, or whether the committee may instead recommend two basic plans and two standard plans, one for use of insurers and the other for use by HMOs which must meet federal requirements.

North Dakota Century Code (N.D.C.C.) ? 26.1-36.3-08(1) directs the Commissioner of Insurance, to "appoint a health benefit plan committee composed of representatives of carriers[1], small employers, employees, health care providers, and producers." This committee is to recommend the form and level of coverage which must be made available to small employers by small employer carriers pursuant to N.D.C.C. ? 26.1-36.3-06. N.D.C.C. ? 26.1-36.3-06 requires "every small employer carrier [to] actively offer small employers at least two health benefit plans." N.D.C.C. ? 26.1-36.3-08(2). Furthermore, the health benefit plan committee

> shall recommend benefit levels, cost sharing

[1]A "carrier" is any entity providing health insurance, including both insurance companies and HMOs. N.D.C.C. ? 26.1-36.3-01(6).

levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan each of which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefits of health maintenanceorganizations, including any restrictions imposed by federal law.

N.D.C.C. ? 26.1-36.3-08(3).

A health benefit plan means any hospital or medical or major medical policy, certificate, or subscriber contract. N.D.C.C. ? 26.1-36.3-01(15)(a). A basic health benefit plan means a lower cost health benefit plan developed under section 26.1-36.3-08. N.D.C.C. ? 26.1-36.3-01(4). The standard health benefit plan means a health benefit plan developed under section 26.1-36.3-08. N.D.C.C. ? 26.1-36.3-01(29).

N.D.C.C. ? 26.1-36.3-09 provides a mechanism for periodic market evaluation of the effectiveness of N.D.C.C. ch. 26.1-36.3 and N.D.C.C. ? 26.1-36-37.2. "[W]hether carriers and producers are fairly and actively marketing and issuing health benefit plans to small employers" must be addressed in this evaluation. To assure fair marketing, N.D.C.C. ? 26.1-36.3-11 sets as a standard that "[e]ach small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to small employers in the state."

The basic health benefit plan is exempted from any law requiring the coverage of a health care service or benefit or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner. N.D.C.C. ? 26.1-36.3-10. This implies that the basic health benefit plan is to meet only the minimum requirements imposed by N.D.C.C. ch. 26.1-36.3. However, HMOs and "qualified" HMOs are required to provide basic health services as defined by federal law. 42 U.S.C. ?? 300e(b)(1) and 300e-9(b)(1). Federal law has defined the basic health services required of HMOs as follows:

The term "basic health services" means -

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(H) preventive health services (including (i) immunizations, (ii) well child care from birth, (iii) periodical health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

42 U.S.C. ? 300e-1(1). Limiting the health benefits plan committee from recommending more than one basic health benefit plan where there are conflicting federal and state requirements for HMOs and non-HMOs is inconsistent with the exemption created by N.D.C.C. ? 26.1-36.3-10 and the requirement of a small employer carrier to offer at least two health benefit plans under N.D.C.C. ? 26.1-36.3-06(1). Therefore, the Legislature's intent in enacting N.D.C.C. ? 26.1-36.3-08(3) must be determined.

The Legislature's intent must be sought initially from the statutory language. County of Stutsman v. State Historical Society, 371 N.W.2d 321, 325 (N.D. 1985). When interpreting statutory language, the words used are to be understood in their ordinary sense unless there is a plain intention to the contrary or the words are otherwise defined in the code. N.D.C.C.

? 1-02-02. Words and phrases used in a statute are construed according to their context and the rules of grammar, but technical words and phrases which have acquired a particular meaning in the law or are defined by statute will be construed according to that meaning. N.D.C.C. ? 1-02-03. Whenever a general provision in a statute is in conflict with a special provision in the same or in another statute, the two must be construed, if possible, so that effect may be given to both provisions, but if the conflict between the two provisions is irreconcilable, the special provision must prevail and must be construed as an exception to the general provision. N.D.C.C. ? 1-02-07.

The waiver of state laws requiring the coverage of health care services or benefits and also waiving the reimbursement, utilization, or inclusion of specific categories of licensed health care practitioners for purposes of the basic health benefit plan is inconsistent with the definition of basic health services required by federal law for HMOs because the federal requirements include coverage of particular health care services or benefits and the inclusion of specific categories of licensed health care practitioners. Therefore, to give effect to both sentences in N.D.C.C. ? 26.1-36.3-08(3) and to construe that section in harmony with N.D.C.C. ch. 26.1-36.3, the health benefit plan committee could recommend a basic health benefit plan and a standard health benefit plan without reference to the federal HMO requirements under the first sentence of N.D.C.C. ? 26.1-36.3-08(3). The committee then could design a basic health benefit plan and a standard health benefit plan which is consistent with the federal HMO requirements under the second sentence of N.D.C.C. ? 26.1-36.3-08(3).

Such an interpretation is also consistent with the marketing objectives under N.D.C.C. ?? 26.1-36.3-09 and 26.1-36.3-11 by offering the small employer more health benefit plans from which to select.

It is therefore my opinion that the health benefit plan committee may design a basic health benefit plan and a standard health benefit plan for non-HMO carriers and the committee may also design a basic health benefit plan and a standard health benefit plan

which are consistent with the basic method of operation and federal requirements concerning HMOs.

Sincerely,

Heidi Heitkamp
ATTORNEY GENERAL

eee/vkk