

**CHAPTER 45-06-13  
PROVIDER-SPONSORED ORGANIZATIONS**

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**45-06-13-01. Definitions.**

1. "Commissioner" means the insurance commissioner of North Dakota.
2. "Department" means the North Dakota insurance department.
3. "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.
4. "Medicare+choice program" means the criteria developed by the Balanced Budget Act of 1997 [Pub. L. 105-33; 111 Stat. 312; 42 U.S.C. 1345 et seq.], whereby risk-bearing organizations are permitted to offer health insurance or health benefits coverage to Medicare-eligible enrollees through a Medicare+choice plan.
5. "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.
6. "Provider-sponsored organization" means a public or private entity that:
  - a. Is established or organized, and operated, by a health care provider, or group of affiliated health care providers;
  - b. Provides a substantial proportion of the health care items and services under the Medicare+choice program directly through the provider or affiliated group of providers; and
  - c. With respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

**History:** Effective August 1, 2000.

**General Authority:** NDCC 26.1-01-07.6

**Law Implemented:** NDCC 26.1-01-07.6

**45-06-13-02. General.**

The commissioner shall issue a certificate of authority for the purpose of providing health care to Medicare enrollees only to a provider-sponsored organization that meets each requirement for the issuance of a certificate of authority as a health maintenance organization as in North Dakota Century Code chapter 26.1-18.1 and other applicable insurance laws and regulations of this state except when preempted by federal law.

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**Law Implemented:** NDCC 26.1-01-07.6

**45-06-13-03. Action.**

The department shall take action on an application required in section 45-06-13-02 within ninety days of the date of receipt of a substantially complete application.

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**Law Implemented:** NDCC 26.1-01-07.6

**45-06-13-04. Minimum net worth requirements.**

Prior to the issuance of a certificate of authority, a provider-sponsored organization must have a minimum net worth amount of:

1. At least one million five hundred thousand dollars except as provided in subsection 2.
2. No less than one million dollars based on evidence from the organization's financial plan demonstrating to the department's satisfaction that the organization has available to it an administrative infrastructure that the department considers appropriate to reduce, control, or eliminate startup administrative costs.
  - a. After the effective date of a provider-sponsored organization's certificate of authority, a provider-sponsored organization shall maintain a minimum net worth amount 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 department for up to and including the first one hundred fifty million dollars of annual premiums and one percent of annual premium revenues on premiums in excess of one hundred fifty million dollars;
    - (3) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with the department; or
    - (4) Using the most recent annual financial statement filed with the department, an amount equal to the sum of:
      - (a) Eight percent of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers;
      - (b) Four percent of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and
      - (c) Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement under subsection 1 and this paragraph.
  - b. The minimum net worth amount shall be calculated as follows:
    - (1) Cash requirement:
      - (a) At the time of the application for a certificate of authority, the provider-sponsored organization shall maintain at least seven hundred fifty

thousand dollars of the minimum net worth amount in cash or cash equivalents.

- (b) After the effective date of a provider-sponsored organization's certificate of authority, a provider-sponsored organization shall maintain the greater of seven hundred fifty thousand dollars or forty percent of the minimum net worth amount in cash or cash equivalents.
- (2) Intangible assets. An organization may include intangible assets, the value of which is based on generally accepted accounting principles, in the minimum net worth amount calculation subject to the following limitations:
- (a) At the time of application:
    - [1] Up to twenty percent of the minimum net worth amount, provided at least one million dollars of the minimum net worth amount is met through cash or cash equivalents; or
    - [2] Up to ten percent of the minimum net worth amount, if less than one million dollars of the minimum net worth is met through cash or cash equivalents, or if the department has used its discretion under this subsection.
  - (b) From the effective date of the provider-sponsored organization's certificate of authority:
    - [1] Up to twenty percent of the minimum net worth amount if the greater of one million dollars or sixty-seven percent of the minimum net worth is met by cash or cash equivalents; or
    - [2] Up to ten percent of the minimum net worth amount if the greater of one million dollars or sixty-seven percent of the minimum net worth amount is not met by cash or cash equivalents.
- (3) Health care delivery assets. Subject to the other provisions of this section, a provider-sponsored organization may apply one hundred percent of the generally accepted accounting principles depreciated value of health care delivery assets to satisfy the minimum net worth amount.
- (4) Other assets. A provider-sponsored organization may apply other assets not used in the delivery care provided that those assets are valued according to statutory accounting practices as defined by the department.
- (5) Subordinated debts and subordinated liabilities. Fully subordinated debt and subordinated liabilities are excluded from the minimum net worth amount calculation.
- (6) Deferred acquisition costs. Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

**History:** Effective August 1, 2000.

**General Authority:** NDCC 26.1-01-07.6

**Law Implemented:** NDCC 26.1-01-07.6

#### **45-06-13-05. Financial plan requirements.**

1. General rule. At the time of application under section 45-06-13-03, an applicant must submit a financial plan acceptable to the department.
2. A financial plan must include:
  - a. A detailed marketing plan;
  - b. Statements of revenue and expense on an accrual basis;
  - c. Statements of sources and uses of funds;
  - d. Balance sheets;
  - e. Detailed justifications and assumptions in support of the financial plan including, when appropriate, certification of reserves and actuarial liabilities by a qualified health maintenance organization actuary; and
  - f. If applicable, statements of the availability of financial resources to meet projected losses.
3. Period covered by the plan. A financial plan shall:
  - a. Cover the first twelve months after the estimated effective date of a provider-sponsored organization's Medicare+choice contract; or
  - b. If the provider-sponsored organization is projecting losses, cover twelve months beyond the end of the period for which losses are projected.
4. Funding for projected losses. Except for the use of guarantees, letters of credit, and other means as provided in section 45-06-13-08, an organization shall have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the provider-sponsored organization's financial plan.
5. Guarantees and projected losses. Guarantees will be an acceptable resource to fund projected losses, provided that a provider-sponsored organization:
  - a. Meets the department's requirements for guarantors and guarantee documents as specified in section 45-06-13-08; and
  - b. Obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows:
    - (1) Prior to the effective date of a provider-sponsored organization's Medicare+choice contract, the amount of the projected losses for the first two quarters;
    - (2) During the first quarter and prior to the beginning of the second quarter of a provider-sponsored organization's Medicare+choice contract, the amount of projected losses through the end of the third quarter; and
    - (3) During the second quarter and prior to the beginning of the third quarter of a provider-sponsored organization's Medicare+choice contract, the amount of projected losses through the end of the fourth quarter.
  - c. If the guarantor complies with the requirements in subdivision b, the provider-sponsored organization, in the third quarter, may notify the department of its intent to reduce the period of advance funding of projected losses. The department shall notify the

provider-sponsored organization within sixty days of receiving the provider-sponsored organization's request if the requested reduction in the period of advance funding will not be accepted.

- d. If the guarantee requirements in subdivision b are not met, the department may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. The department retains discretion to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.
6. Letters of credit. Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to the department. They shall be capable of being promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.
  7. Other means. If satisfactory to the department, and for periods beginning one year after the effective date of a provider-sponsored organization's Medicare+choice contract, a provider-sponsored organization may use the following to fund projected losses:
    - a. Lines of credit from regulated financial institutions;
    - b. Legally binding agreements for capital contributions; or
    - c. Legally binding agreements of a similar quality and reliability as permitted in subdivisions a and b.
  8. Application of guarantees, letters of credit, or other means of funding projected losses. Notwithstanding any other provision of this section, a provider-sponsored organization may use guarantees, letters of credit, and, beginning one year after the effective date of a provider-sponsored organization's Medicare+choice contract, other means of funding projected losses, but only in a combination or sequence that the department considers appropriate.

**History:** Effective August 1, 2000.

**General Authority:** NDCC 26.1-01-07.6

**Law Implemented:** NDCC 26.1-01-07.6

#### **45-06-13-06. Liquidity.**

1. A provider-sponsored organization shall have sufficient cash flow to meet its financial obligations as they become due and payable.
2. To determine whether the provider-sponsored organization meets the requirement in subsection 1, the department will examine the following:
  - a. The provider-sponsored organization's timeliness in meeting current obligations;
  - b. The extent to which the provider-sponsored organization's current ratio of assets to liabilities is maintained at a one to one ratio including whether there is a declining trend in the current ratio over time; and
  - c. The availability of outside financial resources to the provider-sponsored organization.
3. If the department determines that a provider-sponsored organization fails to meet the requirement in subdivision a of subsection 2, the department will require the provider-sponsored organization to initiate corrective action and pay all overdue obligations.

4. If the department determines that a provider-sponsored organization fails to meet the requirement of subdivision b of subsection 2, the department will require the provider-sponsored organization to initiate corrective action to:
  - a. Change the distribution of its assets;
  - b. Reduce its liabilities; or
  - c. Make alternative arrangements to secure additional funding to restore the provider-sponsored organization's current ratio to one to one.
5. If the department determines that a provider-sponsored organization fails to meet the requirement of subdivision c of subsection 2, the department will require the provider-sponsored organization to obtain funding from alternative financial resources.

**History:** Effective August 1, 2000.

**General Authority:** NDCC 26.1-01-07.6

**Law Implemented:** NDCC 26.1-01-07.6

#### **45-06-13-07. Deposits.**

##### **1. Insolvency deposit.**

- a. At the time of application, an organization shall deposit one hundred thousand dollars in cash or securities, or any combination thereof, into an account in a manner that is acceptable to the department.
- b. The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.
- c. At the time of the provider-sponsored organization's application for a certification of authority, and, thereafter, upon the department's request, a provider-sponsored organization shall provide the department with proof of the insolvency deposit, such proof to be in a form that the department considers appropriate.

##### **2. Uncovered expenditures deposit.**

- a. If at any time uncovered expenditures exceed ten percent of a provider-sponsored organization's total health care expenditures, then the provider-sponsored organization must place an uncovered expenditures deposit into an account with any organization or trustee that is acceptable to the department.
- b. The deposit must at all times have fair market value of an amount that is one hundred twenty percent of the provider-sponsored organization's outstanding liability for uncovered expenditures for enrollees, including incurred, but not reported, claims.
- c. The deposit must be calculated as of the first day of each month required and maintained for the remainder of each month required.
- d. If a provider-sponsored organization is not otherwise required to file a quarterly report, it must file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.
- e. The deposit required under this section is restricted and in trust for the department's use to protect the interests of the provider-sponsored organization's Medicare enrollees and to pay the costs associated with administering the insolvency. It may be used only as provided under this section.

3. **Deposit as asset.** A provider-sponsored organization may use the deposits required under subsections 1 and 2 to satisfy the provider-sponsored organization's minimum net worth amount required under section 45-06-13-04.
4. **Income.** All income from the deposits or trust accounts required under subsections 1 and 2 is considered assets of the provider-sponsored organization. Upon the department's approval, the income from the deposits may be withdrawn.
5. **Withdrawal.** On prior written approval from the department, a provider-sponsored organization that has made a deposit under subsection 1 or 2 may withdraw that deposit or any part thereof if:
  - a. A substitute deposit of cash or securities of equal amount and value is made;
  - b. The fair market value exceeds the amount of the required deposit; or
  - c. The required deposit under subsection 1 or 2 is reduced or eliminated.

**History:** Effective August 1, 2000.

**General Authority:** NDCC 26.1-01-07.6

**Law Implemented:** NDCC 26.1-01-07.6

#### **45-06-13-08. Guarantees.**

1. **General policy.** A provider-sponsored organization, or the legal entity of which the provider-sponsored organization is a component, may apply to the department to use the financial resources of a guarantor for the purpose of meeting the requirements in section 45-06-13-05. The department has the discretion to approve or deny approval of the use of a guarantor.
2. **Request to use a guarantor.** To apply to use the financial resources of a guarantor, a provider-sponsored organization must submit to the department the following material:
  - a. Documentation that the guarantor meets the requirements for a guarantor under subsection 3; and
  - b. The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, the profit and loss statements, and cash flow statements.
3. **Requirements for guarantor.** To serve as a guarantor, an organization must meet the following requirements:
  - a. Be a legal entity authorized to conduct business within a state of the United States.
  - b. Not be under federal or state bankruptcy or rehabilitation proceedings.
  - c. Have a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the provider-sponsored organization guarantee.
  - d. If the guarantor is regulated by a state insurance commissioner, or other state official with authority for risk-bearing entities, it must meet the net worth requirement in subdivision c with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.
  - e. If the guarantor is not regulated by a state insurance commissioner or other similar state official, it must meet the net worth requirement in subdivision c with all guarantees and all

investments in and loans to organizations covered by a guarantee and to related parties, subsidiaries, and affiliates excluded from its assets.

4. **Guarantee document.** If the guarantee request is approved, a provider-sponsored organization must submit to the department a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must contain the following provisions:
  - a. State the financial obligation covered by the guarantee;
  - b. Agree to unconditionally fulfill the financial obligation covered by the guarantee;
  - c. Agree not to subordinate the guarantee to any other claim on the resources of the guarantor;
  - d. Declare that the guarantor must act on a timely basis, in any case not more than five business days, to satisfy the financial obligation covered by the guarantee; and
  - e. Meet other conditions as the department may establish from time to time.
5. **Reporting requirement.** A provider-sponsored organization shall submit to the department the current internal financial statements and annual financial statements of the guarantor according to the schedule, manner, and form that the department requests.
6. **Modification, substitution, and termination of a guarantee.** A provider-sponsored organization may not modify, substitute, or terminate a guarantee unless the provider-sponsored organization:
  - a. Requests the department's approval at least ninety days before the proposed effective date of the modification, substitution, or termination;
  - b. Demonstrates to the department's satisfaction that the modification, substitution, or termination will not result in insolvency of the provider-sponsored organization; and
  - c. Demonstrates how the provider-sponsored organization will meet the requirements of this section.
7. **Nullification.** If at any time the guarantor or the guarantee ceases to meet the requirements of this section, the department shall notify the provider-sponsored organization that it ceases to recognize the guarantee document. In the event of this nullification, a provider-sponsored organization shall:
  - a. Meet the applicable requirements of this section within fifteen business days; and
  - b. If required by the department, meet a portion of the applicable requirements in less than the time period granted in subdivision a.

**History:** Effective August 1, 2000.

**General Authority:** NDCC 26.1-01-07.6

**Law Implemented:** NDCC 26.1-01-07.6