Addendum: for use with North Dakota Life and Health online ExamFX courses and study guides version 24816en/24818en, per exam content outline updates effective 3/1/2022.

*The following are **content additions** to supplement your existing text unless otherwise indicated:*

Introduction

Exam Breakdown – *new exam breakdowns*

North Dakota Life Insurance and Annuity Examination
110 Questions; Time Limit: 2.5 hour

CHAPTER	PERCENTAGE OF EXAM
GENERAL KNOWLEDGE	
General Insurance	7%
Life Insurance Basics	12%
Types of Life Insurance Policies	13%
Life Insurance Policy Provisions, Options, and Riders	18%
Annuities	7%
Federal Tax Considerations for Life Insurance and Annuities	4%
STATE LAW:	
Insurance Regulation	14%
Insurance Regulation	25%

North Dakota Accident and Health Insurance Examination
110 Questions; Time Limit: 2.5 hours

CHAPTER	PERCENTAGE OF EXAM
GENERAL KNOWLEDGE	
General Insurance	6%
Accident and Health Insurance Basics	12%
Individual Accident and Health Insurance Policy Provisions	11%
Disability Income and Related Insurance	6%
Medical Plans	14%
Group Health Insurance	4%
Specialized Health Insurance for Qualified Individuals	5%
Federal Tax Considerations for Health Insurance	3%
STATE LAW:	
Insurance Regulation	12%
North Dakota Laws and Regulations Pertaining to Accident and Health Insurance	27%

LIFE AND HEALTH

Insurance Regulation

E. Federal Regulation

National Do Not Call List

In 2003, the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC) worked together to create the **National Do Not Call Registry**, allowing consumers to include their telephone numbers on the list to which solicitation calls cannot be made by telemarketers. Insurance companies need to comply with this regulation when making solicitation phone calls.

To comply with the telemarketing sales rules, telemarketers must not do any of the following:

- Call any number on the National Do Not Call Registry or on that seller's Do Not Call list;
- Deny someone a right to be placed on any Do Not Call Registry;
- Call outside permissible calling hours (before 8 a.m. and after 9 p.m.);
- Abandon calls;
- Fail to transmit caller ID information;
- Threaten or intimidate a consumer or use obscene language; or
- Cause any telephone to ring or engage a person in conversation with the intent to annoy, abuse, or harass the person called.

Some exceptions to the Do Not Call Registry include the following calls:

- From or on behalf of organizations which have established a business relationship with the consumer (established business relationships last 18 months from the date of a sale or transaction);
- For which the consumer has given prior written permission;
- Not commercial or that do not include unsolicited advertisements; and
- By or on behalf of tax-exempt nonprofit organizations.

To keep in compliance with the Do Not Call rules, organizations must consult the registry every **31 days**. Any phone numbers on the registry must be dropped from the organization's call lists.

LIFE ONLY

Life Insurance Policies

A. Term Life Insurance

Increasing Term

Increasing term features level premiums and a death benefit that increases each year over the duration of the policy term. The amount of the increase in the death benefit is usually expressed as a specific amount or a percentage of the original amount.

Increasing term is often used by insurance companies to fund certain riders that provide a *refund of premiums* or a gradual increase in total coverage, such as the cost of living or return of premium riders.

This type of policy would be ideal to handle inflation and the increasing cost of living. It is also often added to another policy as a rider, such as with return of premium policies.

Annuities

E. Uses of Annuities

Long-Term Care Rider

Under the Pension Protection Act of 2006, annuitants are allowed to transfer money from an annuity to pay for long-term care insurance premiums, tax free. In the past, distributions from nonqualified annuities were taxed; however, now, distributions can be used to pay for long-term care premiums and, in many cases, eliminate the taxes on the annuity gains. As a result, many insurers now offer a hybrid annuity with a long-term care feature. These policies provide for income, long-term care, or both.

Qualified Plans – *chapter deleted from the outline (no longer required for the state exam)*

North Dakota Laws and Regulations Pertaining to Life Insurance and Annuities

B. Individual Life Insurance – *addition to the existing text*

- *Reinstatement* — In the event an insured defaults on premium payments, and the value of the policy is applied to purchase other insurance, the original policy may be reinstated within **3 years** of the default. Policy reinstatement may only be issued upon evidence of insurability and payment of past due premiums with interest. Policies surrendered or cancelled are not eligible for reinstatement.

HEALTH ONLY

Health Insurance Basics

F. Process of Issuing a Health Insurance Policy

3. Policy Delivery

Premium Collection Methods

All premiums, return premiums, or other funds received by an agent must be kept in a fiduciary capacity. An agent must, in the regular course of business, account for and pay these funds when due to the insurer, insured, or the insured's assignee. All funds received by an agent must be kept in a fiduciary account which is separate from all other business and personal funds. Funds deposited into the separate fiduciary account must not be commingled or combined with other funds except for the purpose of advancing premiums.

Premiums can be paid physically (by check or cash) or electronically. Payments submitted electronically are considered **electronic funds transfers (EFTs)** and are made through the **Automated Clearing House (ACH)**.

Individual Health Insurance Policy General Provisions

C. Other General Provisions

Coinsurance

Most major medical policies include a **coinsurance** provision that provides for the sharing of expenses between the insured and the insurance company. After the insured satisfies the policy deductible, the insurance company will usually pay the majority of the expenses, typically **80%**, with the insured paying the remaining **20%**. Other coinsurance arrangements exist such as 90/10; 75/25; or 50/50. The larger the percentage that is paid by the insured, the lower the required premium will be. The purpose of the coinsurance provision is for the insurance company to control costs and discourage overutilization of the policy.

Exclusions

Exclusions specify for what the insurer will not pay. These are causes of loss that are specifically excluded from coverage. **Reductions** are a decrease in benefits because of certain specified conditions. The most common exclusions in health insurance policies are injury or loss that results from any of the following:

- War;
- Military duty;
- Self-inflicted injury;
- Dental expense;
- Cosmetic medical expenses;
- Eye refractions; or
- Care in government facilities.

In addition, most policies will temporarily suspend coverage while an insured resides in a foreign country or while serving in the military.

Mental and Emotional Disorders — Usually the lifetime benefit for major medical coverage limits the amount payable for mental or emotional disorders. The benefit is usually expressed as a separate lifetime benefit and there is frequently a limit on the number of outpatient visits per year. The benefit may also pay a maximum limit per visit. These limitations usually do not apply to inpatient treatment.

Substance abuse — As with mental and emotional disorders, outpatient treatment of substance abuse is usually limited to a maximum limit.

Disability Income and Related Insurance

B. Individual Disability Income Insurance

1. Basic Total Disability Plan

Probationary Period

Probationary period is another type of waiting period that is imposed under some disability income policies. It does not replace the elimination period, but is in addition to it. The probationary period is a waiting period, often 10 to 30 days, from the policy issue date during which benefits will not be paid for illness-related disabilities. The probationary period applies to only sickness, not accidents or injury. The purpose for the probationary period is to reduce the chances of adverse selection against the insurer. This helps the insurer guard against those individuals who would purchase a disability income policy shortly after developing a disease or other health condition that warrants immediate attention.

Medical Plans

B. Types of Providers and Plans

1. Major Medical Insurance (Indemnity Plans)

Provisions Affecting Cost to Insurance

Impairment Rider

The **impairment** (exclusion) rider may be attached to a contract for the purpose of eliminating coverage for a specifically defined pre-existing condition, such as back injuries. Impairment riders may be temporary or may become a permanent part of the policy. Attaching this rider excludes coverage for a condition that would otherwise be covered. Often a person's only means of purchasing insurance at a reasonable cost when they have an existing impairment is through a policy which excludes coverage for the specific impairment.

Most riders in both life and health insurance add some form of additional coverage and often, there is extra cost added to the premium for the rider. The impairment (exclusion) rider is an exception in that it takes something **away from** standard coverage. There is no extra charge for this, nor is the premium reduced to reflect a reduction in coverage.

Point-of-Service (POS) Plans

The **Point-Of-Service (POS)** plan is merely a combination of HMO and PPO plans.

With the Point-Of-Service plan the employees do not have to be locked into one plan or make a choice between the two plans. A different choice can be made every time a need arises for medical services.

Out-of-network Provider Access

PPO plans, like HMOs, enter into contractual arrangements with health care providers who form a provider network. However, plan members do not have to use only in-network providers for their care.

Similarly, in a **POS plan** the individuals can visit an in-network provider at their discretion. If they decide to use an out-of-network physician, they may do so. However, the member copays, coinsurance and deductibles may be substantially higher.

In POS plans, participants usually have access to a provider network that is controlled by a primary care physician ("gatekeeping"). Plan members, however, have an option to seek care outside the network, but at reduced coverage levels. POS plans are also referred to as "open-ended HMOs."

PCP Referral

The Point-Of-Service (POS) plan combines "gatekeeping" arrangements with the ability to self-refer at increased out-of-pocket costs. A patient can obtain a higher level of benefits at a lower cost when care is provided by or arranged through the primary care physician (PCP). Benefits for covered services when self-referring (without having your primary care physician arrange for the service) are generally more expensive.

Indemnity Plan Features

If a non-member physician is utilized under the Point-Of-Service plan, then the attending physician will be paid a fee for service, but the member patient will have to pay a higher coinsurance amount or percentage for the privilege.

C. Cost Containment in Health Care Delivery

1. Cost-Saving Services

Managed Care

Managed care plans' main characteristic is that they try to contain costs of health care services while providing efficient services. Strategies used by managed care plans are

- Providing financial incentives for members to use providers and procedures approved by the plan;
- Controlling lengths of hospital stay;
- Using utilization reviews to improve case management;
- Focus on preventive health care.

HMO and PPO plans are some of the examples of managed care plans.

Preauthorization and Second Opinion

Preauthorization is a cost-containment measure requiring that the insured obtain approval from the insurer before getting an expensive surgery, referred to a specialist, or nonemergency healthcare service.

A **second opinion** is a separate assessment of a patient by a different medical professional who will then affirm or modify the patient's diagnosis and treatment plan.

Health Insurance Portability and Accountability Act (HIPAA) – *new section*

Legislation that took effect in July 1997 ensures "**portability**" of group insurance coverage and includes various required benefits that affect small employers, the self-employed, pregnant women, and the mentally ill. HIPAA (Health Insurance Portability and Accountability Act) regulates protection for both **group health plans** (for employers with 2 or more employees) and for **individual insurance policies** sold by insurance companies.

HIPAA includes the following protection for coverage:

Group Health Plans:

- Prohibiting discrimination against employees and dependents based on their health condition; and
- Allowing opportunities to enroll in a new plan to individuals in special circumstances.

Individual Policies:

- Guaranteeing access to individual policies for qualifying individuals; and
- Guaranteeing renewability of individual policies.

Eligibility

HIPAA has regulations regarding eligibility for employer-sponsored group health plans. These plans cannot establish eligibility rules for enrollment under the plan that discriminate based on any health factor relating to an eligible individual or the individual's dependents. A **health factor** includes any of the following:

- Health status;
- Medical conditions (both physical and mental);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Disability; or
- Evidence of insurability, which includes conditions arising out of acts of domestic violence and participation in such activities as motorcycling, skiing, or snowmobiling.

Employer-sponsored group health plans may apply waiting periods prior to enrollment as long as they are applied uniformly to all participants.

To be eligible under HIPAA regulations to convert health insurance coverage from a **group plan** to an **individual policy**, an individual must meet the following criteria:

- Have 18 months of continuous creditable health coverage;
- Have been covered under a group plan in most recent insurance;
- Have used up any COBRA or state continuation coverage;
- Not be eligible for Medicare or Medicaid;
- Not have any other health insurance; and
- Apply for individual health insurance within 63 days of losing prior coverage.

Such HIPAA-eligible individuals are guaranteed the right to purchase individual coverage.

Guaranteed Issue

If the new employee meets the requirements, the employer must offer coverage on a guaranteed issue basis.

Renewability

At the plan sponsor's option, the issuer offering group health coverage must renew or continue in force the current coverage. However, the group health coverage may be discontinued or nonrenewed because of nonpayment of premium, fraud, violation of participation or contribution rules, discontinuation of that particular coverage, or movement outside the service area or association membership cessation.

Privacy Protections

Under the **Privacy Rule** for HIPAA (Health Insurance Portability and Accountability Act), protected information includes all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral. This is called protected health information (PHI).

Individually identifiable health information including demographic data that relates to past, present or future physical or mental health or condition, or payment information that could easily identify the individual.

A covered entity must obtain the individual's written authorization to disclose information that is not for treatment, payment, or health care operations.

The **Security Rules** of HIPAA apply to electronically protected health information that is individually identifiable in electronic form. This includes information about a patient's past, present or future medical condition and payment for health care provision. The Security Rules were established to protect confidentiality, integrity, and availability of electronically protected health information.

Covered entities must comply with the security provisions of HIPAA by maintaining reasonable administrative, physical, and technical safeguards against any reasonably anticipated risks.

E. Affordable Care Act

Essential Health Benefits

As mandated by the Affordable Care Act, all private health insurance plans offered in the Marketplace must provide the same set of essential health benefits. All health care plans must include at least the following **10 essential benefits**:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Pregnancy, maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Dental Insurance – *chapter deleted from the outline (no longer required for the state exam)*

Federal Tax Considerations for Health Insurance

Consumer Driven Health Plans – *new section*

Consumer Driven Plans (also known as Consumer Driven Health Plans, CDHP, High-deductible plans, or patient directed plans) are health care plans that are controlled by the employer. Basically the employee member receives first-dollar coverage from a designated health account (can be an HRA or HSA) until funds are depleted, then a deductible gap must be met before an insurance plan is available to cover additional cost. While other types of plans restrict certain types of coverage, members of a consumer driven plan may use funds from the plan to pay for costs associated with genetic testing or a special nursery school for a child, for instance, without being denied coverage.

Health Reimbursement Accounts (HRAs)

Health Reimbursement Accounts (HRAs) consist of funds set aside by employers to reimburse employees for qualified medical expenses, such as deductibles or coinsurance amounts. Employers qualify for preferential tax treatment of funds placed in an HRA in the same way that they qualify for tax advantages by funding an insurance plan. Employers can deduct the cost of a health reimbursement account as a business expense.

The following are key characteristics of HRAs:

- They are contribution healthcare plans, not defined benefit plans;
- Not a taxable employee benefit;

- Employers' contributions are tax deductible;
- Employees can roll over unused balances at the end of the year;
- Employers do not need to advance claims payments to employees or healthcare providers during the early months of the plan year;
- Provided with employer dollars, not employee salary reductions;
- Permit the employer to reduce health plan costs by coupling the HRA with a high-deductible (and usually lower-cost) health plan; and
- Balance the group purchasing power of larger employers and smaller employers.

In **Health Reimbursement Accounts (HRAs)**, the employer's contribution is tax deductible in the year in which the reimbursement is made to the employee. The employee is not taxed on receipt of the benefit. Benefits must be paid solely to the employee for medical care expenses for the employee, the employee's spouse, or dependents. If funds are distributed for other than medical care expenses, the benefit is considered to be taxable income to the employee.

Flexible Spending Accounts (FSAs)

A **Flexible Spending Account (FSA)** is a form of cafeteria plan benefit funded by salary reduction and employer contributions. The employees are allowed to deposit a certain amount of their paycheck into an account before paying income taxes. Then, during the year, the employee can be directly reimbursed from this account for eligible health care and dependent care expenses. FSA benefits are subject to annual maximum and "use-or-lose" rule. This plan does not provide a cumulative benefit beyond the plan year.

There are 2 types of Flexible Spending Accounts: a Health Care Account for out-of-pocket health care expenses, and a Dependent Care Account (subject to annual contribution limits) to help pay for dependent's care expenses which makes it possible for an employee and his or her spouse to continue to work.

An FSA is exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes, saving 1/3 or more in taxes. If the plan favors highly compensated employees, the benefits for the highly compensated employees are not exempt from federal income taxes.

Child and dependent care expenses must be for the care of one or more qualifying persons:

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or
- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have

constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

The insured may change benefits during open enrollment. After that period, generally, no other changes can be made during the plan year. However, the insured might be able to make a change under one of the following circumstances, referred to as qualified life event changes:

1. Marital status;
2. Number of dependents;
3. One of dependents becomes eligible for or no longer satisfies the coverage requirements under the Medical Reimbursement plan for unmarried dependents due to attained age, student status, or any similar circumstances;
4. The insured, the insured's spouse's or qualified dependent's employment status that affects eligibility under the plan (at least a 31-day break in employment status to qualify as a change in status);
5. Change in dependent care provider; or
6. Family medical leave.

The IRS limits the annual contribution for Dependent Care Accounts to a specified amount that gets adjusted annually for cost of living. This is a family limit, meaning that even if both parents have access to flexible care accounts, their combined contributions cannot exceed the amount.

Insurance Regulation

E. Federal Regulation

Privacy Protection (Gramm-Leach-Bliley)

The Gramm-Leach-Bliley Act stipulates that in general, an insurance company may not disclose nonpublic personal information to a nonaffiliated third party except for the following reasons:

- The insurance company clearly and conspicuously discloses to the consumer in writing that information may be disclosed to a third party;
- The consumer is given the opportunity, before the time that information is initially disclosed, to direct that information not be disclosed to the third party; or
- The consumer is given an explanation of how the consumer can exercise a nondisclosure option.

The Gramm-Leach-Bliley Act requires **2 disclosures** to a customer (a consumer who has an ongoing financial relationship with a financial institution):

1. When the customer relationship is established (i.e. a policy is purchased); and
2. Before disclosing protected information.

The customer must also receive an annual privacy disclosure, and have the right to opt out, or choose not to have their private information shared with other parties.

CAN-SPAM Act

CAN-SPAM legislation was established to set the rules for commercial e-mail, and to give recipients the right to reject commercial messages. CAN-SPAM covers all commercial electronic messages, including business-to-business messages, the purpose of which is the commercial advertisement or promotion of a product or service.

CAN-SPAM requires that any commercial email must contain an opt-out mechanism; all opt-out requests must be honored **within 10 business days**. To be in compliance with this legislation, the entity that sends out e-mails must do the following:

- Make sure that the advertiser is identified in the from line;
- Not use misleading subject lines;
- Include an opt-out mechanism and honor all opt-out requests within 10 days;
- Include the advertiser's valid physical postal address; and
- If the message is unsolicited, it must be identified as an advertisement somewhere in the e-mail.

Each violation of the above provisions is subject to fines of up to $16,000. On top of that is a penalty of $250 per each noncompliant e-mail, with a cap of $2 million dollars.

North Dakota Laws and Regulations Pertaining to Accident and Health Insurance

C. Requirements for Individual and Group Policies

Short-Term Limited-Duration Health Insurance Policies

Short-term limited-duration (STLD) health insurance provides health coverage for a specific amount of time, no longer than:

- **12 months** after the original effective date of the policy; or
- **36 months** from the original effective date of the policy for renewals or extensions.

An insurer must provide an insured with a 15-day notice of cancellation or nonrenewal. If an insured wishes to renew coverage, an insurer is prohibited from subjecting an insured to additional underwriting requirements and must maintain the same risk class as the original policy.

Insurers may only determine rates based on the following criteria:

- Geographic area;
- Tobacco use;
- Family size;
- Age; and
- Gender.

STLD policies must provide the following essential health benefits:

- Ambulatory services;
- Emergency services;
- Hospitalization;
- Pregnancy, maternity, and newborn care;
- Mental health and substance use disorder;
- Prescription drugs;
- Rehabilitative services;
- Laboratory services; and
- Preventive and wellness services.

All marketing materials related to the offering or sale of an individual or association

short-term limited-duration plan must be filed with and approved by the Commissioner before the plan is offered for sale in this state.

Sale of short-term limited-duration plans is only allowed through a **licensed and properly appointed insurance producer**. An insurance producer's signature and identification number must be included on the prospective insured's application.