Office of the Attorney General
State of North Dakota

Opinion No. 84-24

Date Issued: May 10, 1984

Requested by: J. O. Wigen
Commissioner of Insurance

--QUESTIONS PRESENTED--

I.

Whether the words 'insured' and 'subscriber' as used in Sections 26-03.1-04.2 and 26.1-17-13 of the North Dakota Century Code refer to the individual person indemnified against loss.

II.

Whether the 'additional premium' mentioned in Sections 26-03.1-04.1 and 26.1-17-13, N.D.C.C., is subject to the filing, approval, and grievance procedures set out in Sections 26.1-17.16 through 26.1-17-28, N.D.C.C.

III.

Whether the words 'makes available' appearing in Sections 26-03.1-04.1 and 26.1-17-13, N.D.C.C., require the insurance company or health service corporation to notify the individual insured or subscriber of the availability of the option.

--ATTORNEY GENERAL'S OPINION--

I.

It is my opinion that the words 'insured' and 'subscriber' as used in Sections 26-03.1-04.1 and 26.1-17-13, N.D.C.C., refer to the individual person indemnified against loss.

II.

It is my further opinion that the 'additional premium' mentioned in Section 26-03.1-04.1, N.D.C.C., is not subject to the filing, approval, and grievance procedures as set out in Sections 26.1-17-26 through 26.1-17-28, N.D.C.C.

III.

It is my further opinion that the words 'makes available' appearing in Sections 26-03.1-04.1 and 26.1-17-13, N.D.C.C., require the insurance company or health service corporation to notify the individual insured or subscriber of the availability of the option.

--ANALYSES--

I.

Section 26-03.1-04.1, N.D.C.C., contains the following language:

> 26-03.1-04.1. CERTAIN OPTIONS REQUIRED IN GROUP POLICIES. No insurance company authorized to do business in this state shall deliver, issue, execute, or renew any policy of health insurance which includes coverage of medical benefits on a group, blanket, franchise, or association basis unless the insured makes available, at the option of the insured, the following coverages for which an additional premium may be charged:
>
> 1. All drugs and medicines prescribed by the provider of health services.
>
> 2. Services rendered in care administered by chiropractors licensed under chapter 43-06.

Section 26.1-17-13, N.D.C.C., contains the following language:

> 26.1-17-13. GROUP MEDICAL SERVICE CONTRACTS--OPTIONS REQUIRED. A health service corporation may not deliver, issue, execute, or renew any medical service contract on a group, blanket, franchise or association basis unless the corporation makes available, at the option of the subscriber, the following coverages for which an additional premium may be charged:
>
> 1. All drugs and medicines prescribed by the provider of health services.
>
> 2. Services rendered in care administered by chiropractors, licensed under chapter 43-06.

Words are to be understood in their ordinary sense unless a contrary intention plainly appears in the statute. Section 1-02-02, N.D.C.C. The term 'insured' is defined in Section 26-02-02, N.D.C.C., as the 'person indemnified.' That definition is generally accepted for health insurance.

The definition recognized in the cases is that the insured, under a contract of insurance upon property or of health and accident insurance is the person in whose favor the contract is operative and who is indemnified against, or is to receive a certain sum upon the happening of a specified contingency or event. 43 Am Jur.2d Insurance 189 (1982).

Since the individual person is the one indemnified against loss and receives the benefits of the policy, an 'insured' is clearly the individual person. This definition of insured is consistent with the meaning of subscriber as used in the parallel code section for health service corporations in Chapter 26.1-17, N.D.C.C.

Sections 26-03.1-04.1 and 26.1-17-13, N.D.C.C., were contained in House Bill 1637 passed by the 1979 Legislative Assembly and codified in 1979 N.D. Sess. Laws 347, § 2. There is no definition of 'subscriber' in the North Dakota Century Code. However, the contracts of Blue Cross and Blue Shield health service corporation, on file with and approved by the North Dakota Insurance Department, including the comprehensive major medical contract, the physicians service contract, and the hospital service contract, define subscriber as follows:

> Subscriber means you, the individual whose application for membership has been accepted by Blue Cross/Blue Shield of North Dakota and in whose name the Identification Card is issued.

The term 'subscriber' is also used in other sections of Chapter 26.1-17, N.D.C.C., which clearly delineate the meaning of 'subscriber' to be the individual person. Examples are Section 26.1-17-02, N.D.C.C., which states that the purpose for organizing non-profit health service corporations is 'for the purposes of establishing and putting into effect a health service plan whereby one or more kinds of health service is provided to subscribers under a contract entitling each subscriber to certain specified health service.' Section 26.1-17-04, N.D.C.C., provides for membership on the board of directors of a health service corporation by subscribers. Such membership can only be by an individual person.

It is clear from the language that the statutes are referring to individual human beings when speaking of the 'insured' or 'subscriber.'

II.

Section 26-02.1-04, N.D.C.C., is limited in application to 'insurance companies' and therefore to 'additional premiums' charged by insurance companies. 'Insurance company' is defined in Section 26.1-02.01(4), N.D.C.C., to include 'any corporation, association, benefit society, exchange, partnership, or individual engaged as principal in the business of insurance.' Sections 26.1-17-26, 26.1-17-27, and 26.1-17-28, N.D.C.C., encompass the requirements for a health service corporation in submitting a rate filing to the Commissioner of Insurance, the procedure for approval or disapproval of the rate filing by the Commissioner, the requirements for informing subscribers after receipt of a written

request of pertinent information as to the rate filing and the procedure for a person aggrieved by the applications of a rate filing to seek review.

These sections speak only to the regulation of health service corporations and do not cover any other entities included in the definition of 'insurance companies.' Consequently, these three sections do not apply to the broader category of insurance companies.

They do in fact spell out the particular procedure for rate regulation of health service corporations and ultimately the determination of their premium. The rate is the formula by which the premium is calculated and the premium is the product of the application of the rate to the specific risk. Medical Malpractice Insurance Association v. Community General Hospital of Sullivan County, 423 N.Y.S.2d 666, 668, 73 A.D.2d 67 (1980).

Since the additional premium would have to be developed as a product of the rate, it would be subject, in the case of a health service corporation, to Sections 26.1-17-26, 26.1-17.-27, and 26.1-17-28, N.D.C.C., insofar as the rate is subject to and determined by those sections. The premium charged by and the rates used by an insurance company are subject to the more general approval requirements of Section 26-03-04, N.D.C.C.

III.

The phrase 'makes available' is not defined in the chapters or sections relevant to insurance companies or medical service corporations. It is clear that the obligation or affirmative duty embodied in the language of Sections 26-03-04.1 and 26.1-17-13, N.D.C.C., fall upon the 'insurance company' or 'insurer' under Section 26-03.1-04.1, N.D.C.C., and upon the 'health service corporation' or 'corporation' in Section 26.1-17-13, N.D.C.C. 'Available' is defined in Black's Law Dictionary:

Available. Suitable; useable; assessable; obtainable; present or ready for immediate use. Having sufficient force or efficacy; effectual; valid. Black's Law Dictionary, 123 (5th Ed. 1979).

The appropriate meaning for 'available' in Black's Law Dictionary in the context of this case is 'assessable' and 'obtainable.' DeKay v. DeKay Pneumatic Tools, 281 P.2d 76, 81, 131 Ca.2d 625 (1955). Section 1-02-02, N.D.C.C., requires that words used in statutes are to be understood in their ordinary sense, unless a contrary intention plainly appears.

The overall intent of the sections as expressed in the committee testimony on House Bill 1637 was to require insurance companies and health service corporations to provide a means for an insured or subscriber to obtain the coverage set out in Sections 26-03-04.1 and 26.1-17-13, N.D.C.C.

Prior to obtaining insurance and to that coverage being assessable, there must be knowledge that it exists. In order to meet the obligation of the phrase 'makes available,' the

insurer or corporation has to inform the insured or subscriber that such coverage is obtainable and provide that individual with the option to select the coverage. To be completely assessable and obtainable at the option of the insured or subscriber, that insured or subscriber must be provided an individual choice as to whether to elect to take that coverage for the additional premium charge. Neither Sections 26-03-04.1 nor 26.1-17-13, N.D.C.C., state that the option is that of the insurer or corporation or the contract holder. It is, rather, the option of the insured or the subscriber, which is clearly the individual person.

--EFFECT--

This opinion is issued pursuant to Section 54-12-01, N.D.C.C. It governs the actions of public officials until such time as the questions presented are decided by the courts.

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