INSURANCE

CHAPTER 298

HOUSE BILL NO. 1073
(Legislative Council)
(Legislative Audit and Fiscal Review Committee)

PREMIUM TAX AND ANNUAL STATEMENT DUE DATES

AN ACT to amend and reenact sections 26-01-11 and 26-07-05 of the North Dakota Century Code, relating to the tax on insurance premiums and the filing date of an annual statement by insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-01-11 of the 1979 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-01-11. COMMISSIONER OF INSURANCE TO COLLECT PREMIUM TAX - INSURANCE COMPANIES GENERALLY - DOMESTIC FIRE INSURANCE COMPANIES - COMPUTATION. Before issuing the annual certificate required by law, the commissioner of insurance shall collect the following annual taxes from insurance companies doing business within the state:

1. From every insurance company doing business in this state except stock and mutual companies organized under the laws of this state, a tax equal in amount to two and one-half percent of the gross amount of premiums, membership fees, and policy fees received in this state during the preceding year, such tax to be payable at the time when the annual statement of business required by law is filed; provided, however, that this tax shall not apply to considerations for annuities.

2. From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. Such tax shall be collected for the purpose of assisting in the maintenance of the fire marshal's department and shall be payable on or before ~~April~~ March first in each year.

SECTION 2. AMENDMENT. Section 26-07-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-07-05. EACH COMPANY REQUIRED TO FILE ANNUAL STATEMENT. Every insurance company doing business in this state shall transmit to the commissioner of insurance, not later than the first day of ~~April~~ March in each year, a statement of its condition and business for the year ending on the preceding thirty-first day of December. An insurance company organized under the law of any foreign country or province shall include in such statement only business transacted within the United States of America, and shall file a supplemental statement of business transacted without the United States not later than the first day of December. The commissioner, upon the receipt in his office of any such statement, shall stamp the date of the receipt thereon. He shall not accept the annual statement from any company if the same was transmitted after the date designated in this section unless the same is accompanied by the penalty prescribed in this chapter for each day's delinquency in the filing thereof.

Approved February 18, 1981

CHAPTER 299

HOUSE BILL NO. 1622
(Crabtree, Wald)

AUTOMOBILE INSURANCE POLICY SPOUSE EXCLUSION

AN ACT to create and enact a new section to chapter 26-02 of the North Dakota Century Code, relating to the exclusion of a spouse of the named insured from coverages under a private passenger automobile insurance liability policy.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26-02 of the North Dakota Century Code is hereby created and enacted to read as follows:

EXCLUSION OF SPOUSE OF NAMED INSURED. No insurer shall be responsible under a private passenger automobile insurance policy covering an automobile registered or principally garaged in this state from any liability for any claims resulting from the operation of the motor vehicle by either a husband or wife of the named insured who reside in the same household if an endorsement on the policy excludes the other spouse from coverage under the policy and the spouse excluded signs the endorsement. If the named insured gives his express or implied consent to the operation of a secured motor vehicle by a spouse excluded under the policy, the named insured shall not be relieved of personal liability as provided by subsection 5 of section 26-41-04.

Approved March 11, 1981

CHAPTER 300

HOUSE BILL NO. 1453
(Representatives Wentz, Wagner)
(Senators Lips, Stenehjem)

LEGAL EXPENSE INSURANCE

AN ACT to create and enact a new section to chapter 26-02 of the North Dakota Century Code, relating to the definition of legal expense insurance, and to create and enact new subsections to sections 26-08-02, 26-14-07, and 26-17.1-07 of the North Dakota Century Code, relating to the establishment of legal expense insurance as an authorized line of insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26-02 of the North Dakota Century Code is hereby created and enacted to read as follows:

"LEGAL EXPENSE INSURANCE" DEFINED. Legal expense insurance, as authorized in this title, means insurance which involves the assumption of a contractual obligation to reimburse the beneficiary against or on behalf of the beneficiary, all or a portion of his fees, cost, or expenses related to or arising out of services by or under the supervision of an attorney licensed to practice law in this state, regardless of whether the payment is made by the beneficiaries individually or by a third party for them, but does not include the provision of or reimbursement for legal services incidental to other insurance coverages. Unless otherwise provided, this title shall not apply to:

1. Plans licensed under the Prepaid Legal Services Act.

2. Retainer contracts made by attorneys with individual clients with fees based upon an estimate of the nature and amount of services to be provided to a specific client and similar contracts made with a group of clients involved in the same or closely related legal matters.

3. Employee welfare benefit plans as defined by the Employee Retirement Income Security Act of 1974.

SECTION 2. A new subsection to section 26-08-02 of the North Dakota Century Code is hereby created and enacted to read as follows:

Legal expense insurance.

SECTION 3. A new subsection to section 26-14-07 of the North Dakota Century Code is hereby created and enacted to read as follows:

Legal expense insurance.

SECTION 4. A new subsection to section 26-17.1-07 of the North Dakota Century Code is hereby created and enacted to read as follows:

Legal expense insurance.

Approved March 11, 1981

CHAPTER 301

HOUSE BILL NO. 1059
(Legislative Council)
(Interim Health Care Committee)

NURSING HOME COVERAGE POLICY

AN ACT to create and enact a new section to chapter 26-03 and a new subdivision to subsection 9 of section 26-30-04 of the North Dakota Century Code, relating to nursing home policies, requiring such policies to be guaranteed renewable for life, limiting preexisting conditions, and unfair claims settlement practices.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26-03 of the North Dakota Century Code is hereby created and enacted to read as follows:

NURSING HOME POLICIES - GUARANTEED RENEWABLE FOR LIFE - LIMITATION ON PREEXISTING CONDITIONS. Any policy providing benefits for confinement to a nursing home shall be guaranteed renewable for life. For the purposes of this section, the term "guaranteed renewable" means a policy which the insured has the right to continue in force for life subject to its terms by the timely payment of premiums during which the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. The insurer may, however, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who are placed in the same class for purposes of rate determination in the process of issuance of the policy or making it guaranteed renewable.

A policy providing nursing home coverage shall contain no provision limiting payment of benefits due to preexisting conditions of the insured after the policy has been in force for a period of six months.

SECTION 2. A new subdivision to subsection 9 of section 26-30-04 of the North Dakota Century Code is hereby created and enacted to read as follows:

Providing coverage under a policy for confinement to a nursing home and refusing to pay a claim when a person

covered by such a policy was confined to a hospital for three days or more and the person's physician ordered confinement for care other than custodial care. Custodial care means care which is primarily for the purpose of meeting personal needs without supervision by a registered nurse or a licensed practical nurse.

Approved March 5, 1981

CHAPTER 302

HOUSE BILL NO. 1438
(Representatives Dietz, Haugland, Retzer)
(Senators Reiten, Quail)

MEDICARE SUPPLEMENT POLICY STANDARDS

AN ACT to provide minimum standards for medicare supplement insurance policies, to set out responsibilities of the commissioner of insurance, and to provide for an outline of coverage of such policies to be delivered to potential purchasers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. DEFINITIONS. Wherever used or referred to in this Act, unless a different meaning clearly appears from the context:

1. "Applicant" means:

   a. In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

   b. In the case of a group medicare supplement policy or subscriber contract, the proposed certificate holder.

2. "Certificate" means any certificate issued under a group medicare supplement policy, which policy has been delivered or issued for delivery in this state.

3. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1935, as amended [Pub. L. 92-603; 86 Stat. 1370].

4. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. Such term does not include:

a. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

b. A policy or contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.

c. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this Act.

SECTION 2. STANDARDS FOR POLICY PROVISIONS.

1. The commissioner of insurance shall issue reasonable rules pursuant to chapter 28-32 to establish specific standards for policy provisions of medicare supplement policies. Such standards shall be in addition to and in accordance with applicable laws of this state, and may cover, but shall not be limited to:

a. Terms of renewability.

b. Initial and subsequent conditions of eligibility.

c. Nonduplication of coverage.

d. Probationary periods.

e. Benefit limitations, exceptions, and reductions.

f. Elimination periods.

g. Requirements for replacement.

h. Recurrent conditions.

i. Definitions of terms.

2. The commissioner of insurance may adopt rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner of insurance, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

3. Notwithstanding any other provisions of the law, a medicare supplement policy may not deny a claim for losses incurred for more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

SECTION 3. MINIMUM STANDARDS FOR BENEFITS. The commissioner of insurance shall adopt rules to establish minimum standards for benefits under medicare supplement policies.

SECTION 4. LOSS RATIO STANDARDS. Medicare supplement policies shall be expected to return benefits to individual policyholders in the aggregate of not less than sixty percent of premium received. The commissioner of insurance shall adopt rules to establish minimum standards for medicare supplement policy loss ratios on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of rules adopted pursuant to this section, medicare supplement policies issued as a result of individual solicitations through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

SECTION 5. DISCLOSURE STANDARDS.

1. To provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy shall be delivered or issued for delivery in this state and no certificate shall be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time application is made.

2. The commissioner of insurance shall prescribe the format and content of the outline of coverage required by subsection 1. For purposes of this section, "format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of

type and the arrangement of text and captions. Such outline of coverage shall include:

a. A description of the principal benefits and coverage provided in the policy.

b. A statement of the exceptions, reductions, and limitations contained in the policy.

c. A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

d. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

3. The commissioner of insurance may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner of insurance may require by rule that the information brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner of insurance may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare by reason of age, but in no event later than the time of policy delivery.

4. The commissioner of insurance may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

a. Medicare supplement policies;

b. Disability income policies;

c. Basic, catastrophic, or major medical expense policies;

d. Single premium, nonrenewable policies; or

e. Other policies defined in subsection 4 of section 1 of this Act.

5. The commissioner of insurance may also adopt rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for medicare.

SECTION 6. NOTICE OF FREE EXAMINATION. Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within ten days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for medicare shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason.

Approved March 12, 1981

CHAPTER 303

HOUSE BILL NO. 1472
(Richie, Hedstrom)

LIFE AND ACCIDENT AND HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT

AN ACT to provide for the adoption of the national association of insurance commissioners' Life and Accident and Health Insurance Policy Language Simplification Act.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. TITLE. This Act may be cited as the "Life and Accident and Health Insurance Policy Language Simplification Act".

SECTION 2. PURPOSE. The purpose of this Act is to establish minimum standards for language used in policies, contracts and certificates of life insurance, accident and health insurance, credit life insurance and credit health insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.

This Act is not intended to increase the risk assumed by insurance companies or other entities subject to this Act or to supersede their obligation to comply with the substance of other insurance legislation applicable to life, accident and health, credit life or credit health insurance policies. This Act is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

SECTION 3. DEFINITIONS. As used in this Act:

1. "Policy" or "policy form" means any policy, contract, plan or agreement of life or accident and health insurance, including credit life insurance and credit health insurance, delivered or issued for delivery in this state by any company subject to this Act; any certificate, contract or policy issued by a fraternal benefit society; and any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state.

2. "Company" or "insurer" means any life or health insurance company, fraternal benefit society, nonprofit health service corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organization.

3. "Commissioner" means the insurance commissioner of this state.

SECTION 4. APPLICABILITY.

1. This Act shall apply to all policies delivered or issued for delivery in this state by any company on or after the date such forms must be approved under this Act, but nothing in this Act shall apply to:

   a. Any policy which is a security subject to federal jurisdiction.

   b. Any group policy covering a group of one thousand or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy. However, this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state.

   c. Any group annuity contract which serves as a funding vehicle for pension, profit sharing, or deferred compensation plans.

   d. Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this Act.

   e. The renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under this Act.

2. No other statute of this state setting language simplification standards shall apply to any policy forms.

SECTION 5. MINIMUM POLICY LANGUAGE SIMPLIFICATION STANDARDS.

1. In addition to any other requirements of law, no policy forms, except as stated in section 4, shall be delivered or issued for delivery in this state on or after the dates such forms must be approved under this Act, unless:

a. The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3 of this section.

b. It is printed, except for specification pages, schedules and tables, in not less than ten point type, one point leaded.

c. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders.

d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed or three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

2. For the purpose of this section, a Flesch reading ease test score shall be measured by the following method:

a. For policy forms containing ten thousand words or less of text, the entire form shall be analyzed. For policy forms containing more than ten thousand words, the readability of two 2-hundred word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least twenty printed lines.

b. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen thousandths.

c. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six-tenths.

d. The sum of the figures computed under subdivisions b and c subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.

e. For purposes of subdivisions b, c, and d of subsection 2 of section 5, the following procedures shall be used:

(1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word.

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

f. The term "text" as used in this section shall include all printed matter except the following:

(1) The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules or tables.

(2) Any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words which are defined in the policy, and any policy language required by law or regulation, provided, however, the insurer identifies the language or terminology excepted by this paragraph (2) and certifies, in writing, that the language or terminology is entitled to be excepted by this paragraph (2).

3. Any other reading test may be approved by the commissioner for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

4. Filings subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with section 7 of this Act. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

5. At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

SECTION 6. CONSTRUCTION. Nothing in this Act shall be construed to negate any law of this state permitting the issuance of

any policy form after it has been on file for the time period specified.

SECTION 7. POWERS OF THE COMMISSIONER. The commissioner may authorize a lower score than the Flesch reading ease score required in subdivision a of subsection 1 of section 5, whenever, in his sole discretion, he finds that a lower score:

1. Will provide a more accurate reflection of the readability of a policy form.

2. Is warranted by the nature of a particular policy form or type or class of policy forms.

3. Is caused by certain policy language which is drafted to conform to the requirements of any state law, regulation or agency interpretation.

SECTION 8. APPROVAL OF FORMS. A policy form meeting the requirements of paragraph (1) of section 5 shall be approved notwithstanding the provisions of any other laws which specify the contents of policies, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

SECTION 9. EFFECTIVE DATE.

1. Except as provided in section 4, this Act applies to all policy forms filed on or after July 1, 1982. No policy form shall be delivered or issued for delivery in this state on or after July 1, 1986, unless approved by the commissioner or permitted to be issued under this Act. Any policy form which has been approved or permitted to be issued prior to July 1, 1986, and which meets the standards set by this Act need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this state upon the filing with the commissioner of a list of such forms identified by form number and accompanied by a certificate as to each such form in the manner provided in subsection 4 of section 5.

2. The commissioner may, in his sole discretion, extend the dates in subsection 1.

Approved March 12, 1981

CHAPTER 304

SENATE BILL NO. 2241
(Lips)

INSURANCE COMPANY NOTE INVESTMENT AUTHORITY

AN ACT to amend and reenact subsection 3 of section 26-08-11 of the North Dakota Century Code, relating to the authorized investments of domestic insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26-08-11 of the 1979 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. Notes secured by mortgages on improved unencumbered real estate, including leaseholds substantially having and furnishing the rights and protection of a first real estate mortgage, within ~~this state or within any state in which such company is, or becomes, authorized and licensed to transact business, or within any state contiguous to the state of North Dakota~~ the United States of America or any province of the Dominion of Canada. No loan may be made under this subsection unless ~~the property mortgaged is worth double the amount of the loan secured by the mortgage, except that where a loan is amortized on the basis of a final maturity twenty-five years or less from the date of the loan, it may be made in an amount not exceeding seventy-five percent of the value of the property mortgaged~~ at the date of acquisition the total indebtedness secured by such lien shall not exceed seventy-five percent of the value of the property upon which it is a lien. The mortgage loan may be made in an amount exceeding seventy-five percent so long as any amount over seventy-five percent of the value of the property mortgaged is guaranteed or insured by the federal housing administration or guaranteed by the administrator of veteran affairs or is insured by a private mortgage insurance through an insurance company authorized to do business in this state. Loans may be amortized on the basis of a final maturity not exceeding thirty years from the date of the loan with an actual maturity date of the

loan at any time less than thirty years. However, a loan on a single-family dwelling where the loan is amortized on the basis of a final maturity twenty-five years or less from the date of the loan may be made in an amount not exceeding eighty percent of the value of the property mortgaged. The loan on a single-family dwelling may be made in an amount exceeding eighty percent so long as any amount over eighty percent of the value of the property mortgaged is insured by private mortgage insurance through an insurance company authorized to do business in this state. Buildings shall not be included in the valuation of such property unless they are insured and the policies are made payable to the company as its interest may appear. In no event shall a loan be made in excess of the amount of insurance carried on the buildings plus the value of the land. No insurance company shall hold less than the entire loan represented by such bonds or notes described in this subsection except that a company may own part of an aggregate obligation if all other participants in the investment are insurance companies authorized to do business in North Dakota or banks whose depositors are insured by the federal deposit insurance corporation or savings and loan associations whose members are insured by the federal savings and loan insurance corporation or unless the security of said bonds or notes, as well as all collateral papers, including insurance policies, executed in connection therewith, are made to and held by a trustee, which trustee shall be a solvent bank or trust company having a paid-in capital of not less than two hundred fifty thousand dollars, except in case of banks or trust companies incorporated under the laws of the state of North Dakota, wherein a paid-in capital of not less than one hundred thousand dollars shall be required, and that in case of proper notification of default such trustee, upon request of at least twenty-five percent of the holders of the bonds outstanding, and proper indemnification, shall proceed to protect the rights of such bondholders under the provisions of the trust indentures.

Approved March 12, 1981

CHAPTER 305

SENATE BILL NO. 2097
(Tennefos)

INSURANCE COMPANY SAVINGS INVESTMENTS

AN ACT to amend and reenact subsection 9 of section 26-08-11 of the North Dakota Century Code, relating to authorized investments of domestic insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 9 of section 26-08-11 of the 1979 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

9. ~~Shares---and---savings---in--domestic--building--and--loan associations-and-federal-savings--and--loan--associations, and--shares--and-savings-in-building-and-loan-associations organized-under-the-laws-of-other-states,-if--such--shares and--savings--are--insured-by-the-federal-savings-and-loan insurance-corporation.~~

a. Savings accounts, under certificates of deposit or in any other form, in solvent banks and trust companies which have qualified for federal deposit insurance corporation protection. Investments in such savings accounts shall not be limited to, or by, the amount of any such insurance protection.

b. Shares and savings accounts, under certificates of deposit or in any other form, in solvent building and loan or savings and loan associations organized under federal law or state law of this or any other state which have qualified for federal savings and loan insurance corporation protection. Investments in such shares and savings accounts shall not be limited to, or by, the amount of any such insurance protection.

c. Shares and deposit accounts, under certificates of deposit or in any other form, in solvent state or federally chartered credit unions which are insured by the national credit union administration. Investments in such shares and deposit accounts shall not be limited to, or by, the amount of any such insurance protection.

Approved March 19, 1981

CHAPTER 306

SENATE BILL NO. 2244
(Lips)

INSURANCE COMPANY DATA PROCESSING SYSTEM INVESTMENT

AN ACT to authorize domestic insurance companies to invest funds in the purchase of electric or mechanical machines constituting a data processing system, and to hold such system as an admitted asset for use in the company's business.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. DATA PROCESSING EQUIPMENT. Any domestic insurance company heretofore or hereafter organized under any law of this state may invest by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof in the purchase of electric or mechanical machines constituting a data processing system, and thereafter may hold the system as an admitted asset for use in connection with the business of the company if, (1) its aggregate cost shall not exceed five percent of the admitted assets of the company; (2) the cost of the component machines constituting the system shall be fully amortized over a period of not to exceed ten years. If a data processing system consists of separate component machines which are acquired at different times, then the cost of each component shall be amortized over a period not to exceed ten years commencing with the date of acquisition of each component.

Approved March 6, 1981

CHAPTER 307

SENATE BILL NO. 2425
(R. Christensen, Wenstrom)

FRATERNAL BENEFIT SOCIETY MORTALITY TABLE USE

AN ACT to amend and reenact subsection 3 of section 26-12-08, subsection 6 of section 26-12-16, subsection 2 of section 26-12-17, and sections 26-12-24 and 26-12-34 of the North Dakota Century Code, relating to fraternal benefit societies and the mortality tables and interest assumptions made with respect to their policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26-12-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. Pay or allow, nor offer nor promise to pay or allow, to any person any death or disability benefit until:

   a. Actual bona fide applications for death benefit certificates shall have been secured upon at least five hundred lives for at least one thousand dollars each;

   b. All of such applicants shall have been examined regularly by legally qualified practicing physicians and certificates of such examinations shall have been filed and approved by the chief medical examiner of the society;

   c. There shall have been established at least ten subordinate lodges or branches into which the five hundred applicants for membership have been initiated;

   d. There shall have been submitted to the commissioner of insurance, under the oath of the president and secretary or corresponding officers of the society, a list of the applicants for membership giving their names, addresses, the dates upon which they were examined, the date of the approval of the examinations, the name and number of the subordinate

lodge or branch of which each applicant is a member, the amount of benefits to be granted by the society, the society's rate of stated periodical contributions which shall be sufficient to provide for meeting the mortuary obligations contracted when valued for death benefits upon the basis of the National Fraternal Congress Table of Mortality and four percent interest or any higher standard at the option of the society, or any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, and the society's rate of stated periodical contributions for disability benefits by tables based upon reliable experience with an interest assumption not higher than four percent per annum; and

e. It shall have been shown to the commissioner of insurance by the sworn statement of the treasurer or corresponding officer of the society that at least five hundred applicants have paid each in cash at least one regular monthly payment as provided in this section for each one thousand dollars of indemnity to be effected. Such payments, in the aggregate, shall amount to at least twenty-five hundred dollars. Such advance payments, during the period of organization, shall be held in trust and shall be credited to the mortuary or disability funds on account of such applicants, and no part of same may be used for expenses. If the organization of the society is not completed within one year as provided in this chapter, such payments shall be returned to the applicants.

SECTION 2. AMENDMENT. Subsection 6 of section 26-12-16 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

6. If it shall show by the annual valuation provided for in this chapter that it is accumulating and maintaining a reserve not lower than the usual reserve computed by the American Experience Table and four percent interest, or any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, issuance of endowment certificates, and the granting to its members extended and paid-up protection or such withdrawal equities, as its constitution and laws may provide. Such grants, however, in no case shall exceed in value the portion of the reserves to the credit of the members to whom the same are made.

SECTION 3. AMENDMENT. Subsection 2 of section 26-12-17 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. The contributions to be made upon certificates issued under the provisions of this section shall be based upon

the Standard Industrial Mortality Table and three and one-half percent, or upon the English Life Table Number Six, or upon ~~such other mortality table as may be approved by the commissioner~~ any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies.

SECTION 4. AMENDMENT. Section 26-12-24 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-12-24. FUNDS OF FRATERNAL BENEFIT SOCIETY - EMERGENCY - SURPLUS - HOW DERIVED - USE - CONTRIBUTIONS REQUIRED. Any fraternal benefit society may create, maintain, invest, disburse, and apply an emergency, surplus, or other similar fund in accordance with its laws. Unless otherwise provided in the contract of the society, such funds shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment or to the surrender of any part thereof, except as provided in subsection 6 of section 26-12-16. The funds from which benefits shall be paid, and the funds from which the expenses of the society shall be defrayed, shall be derived from periodical or other payments by the members of the society and the accretions of said funds. No domestic society shall be incorporated, and no foreign society shall be admitted to transact business in this state unless it shall require stated periodical contributions sufficient to provide for meeting the mortuary obligations contracted by the society when the same are valued upon the basis of the National Fraternal Congress Table of Mortality, or upon the basis of any higher standard, with interest assumption at not more than four percent per annum, or upon any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, and no such society shall write or accept members for temporary or permanent disability benefits within this state except upon tables based upon reliable experience, with an interest assumption not higher than four percent per annum.

SECTION 5. AMENDMENT. Section 26-12-34 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-12-34. REPORT OF CERTIFICATE VALUATION - VERIFICATION - MINIMUM STANDARD OF VALUATION. Annually, and within ninety days after the submission of the last preceding annual report, each fraternal benefit society transacting business in this state shall file with the commissioner of insurance a report showing the valuation of its certificates in force on the thirty-first day of December last preceding, and including those issued within the year for which the report is filed in cases where the contributions for the first year are used in whole or in part for current mortality and expense payments. Such valuation shall be certified by a competent accountant or actuary, or, at the request and expense of the society, verified by the actuary of the department of insurance of the home state, territory, or province of the society. The legal minimum standard of valuation for all certificates, except for

disability benefits, shall be the National Fraternal Congress Table of Mortality and four percent interest, or, at the option of the society any higher table or a table based upon the society's own experience of at least twenty years and covering not less than one hundred thousand lives, with interest assumption of not more than four percent per annum, or any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, or any table and interest rate producing greater aggregate net values than those herein above prescribed, such as the Commissioners 1941 Standard Ordinary Table. Each such valuation report shall set forth clearly and fully the mortality and interest basis and the method of valuation. Any society providing for disability benefits shall keep the net contributions for such benefits in a fund separate and apart from all other benefit and expense funds and the valuation of all other business of the society. Where a combined contribution table is used by a society for both death and permanent total disability benefits, however, the valuation shall be according to tables of reliable experience and in such case, a separation of the funds shall not be required.

Approved March 6, 1981

CHAPTER 308

HOUSE BILL NO. 1058
(Legislative Council)
(Interim Health Care Committee)

INTERCARRIER HEALTH INSURANCE POOL

AN ACT to establish an intercarrier health insurance pool through an association of insurers, to designate a lead carrier to administer the plan of coverage, and to authorize the state insurance commissioner to act as the regulatory authority; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. DEFINITIONS. In this Act, unless the subject matter or context requires otherwise:

1. "Accident and sickness insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage which is (a) limited to disability or income protection coverage, (b) automobile medical payment coverage, (c) supplemental to liability insurance, (d) designed solely to provide payment on a per diem basis, daily indemnity, or non-expense-incurred basis, or (e) credit accident and sickness insurance.

2. "Association plan premium" means the charge for membership in the association plan based on the benefits provided in sections 3 or 4 of this Act and determined pursuant to section 5 of this Act.

3. "Commissioner" means the state commissioner of insurance.

4. "Comprehensive health association" or "association" means the association created by section 7 of this Act.

5. "Comprehensive health insurance plan" or "association plan" means a policy of insurance coverage offered by the association through the lead carrier.

6. "Eligible person" means an individual who is a resident of North Dakota and meets the enrollment requirements of section 11 of this Act.

7. "Fraternal benefit society" or "fraternal" means a corporation, society, order, or volunteer association without capital stock which sells accident and sickness insurance in accordance with chapter 26-12.

8. "Health benefits" means benefits offered on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible person, chiropractic care.

9. "Insurer" means those companies operating pursuant to chapters 26-03.1, 26-26, or 26-27, and offering or selling policies or contracts of accident and sickness insurance. Insurer does not include health maintenance organizations.

10. "Lead carrier" means the insurer selected by the association to administer the comprehensive health insurance plan.

11. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of individual accident and sickness insurance policies or coverage under a nonprofit health service plan.

12. "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by sections 3 or 4 of this Act or the actuarial equivalent of those benefits.

SECTION 2. CERTIFICATION OF QUALIFIED PLANS. Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of this Act, the commissioner shall make a determination within ninety days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified plan A", "qualified plan B", or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

SECTION 3. MINIMUM BENEFITS OF A QUALIFIED PLAN A.

1. A plan of health coverage shall be a number three qualified plan A if it otherwise meets the requirements established by chapter 26-03.1, and other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

   a. The minimum benefits for covered individuals shall, subject to the other provisions of this subdivision, be equal to at least eighty percent of the cost of

covered services in excess of an annual deductible which does not exceed one hundred fifty dollars per person. The coverage shall include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

b. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

(3) Use of radium or other radioactive materials.

(4) Oxygen.

(5) Anesthetics.

(6) Diagnostic X-rays and laboratory tests.

(7) Services of a physical therapist.

(8) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

c. Covered expenses shall also include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include the following:

(1) Drugs requiring a physician's prescription.

(2) Services of a nursing home.

(3) Services of a home health agency.

(4) Home and office calls.

(5) Prostheses.

(6) Rental or purchase of durable medical equipment.

(7) The first twenty dollars of diagnostic X-ray and laboratory charges in each fourteen-day period.

(8) Oral surgery.

(9) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent to self-insurance, or for which benefits are payable under another policy of accident and sickness insurance or medicare.

(10) Any charge for treatment for cosmetic purposes other than for surgery for the repair of an injury or birth defect.

(11) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(12) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(13) That part of a charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(14) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(15) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

2. A plan of coverage shall be certified as a number two qualified plan A if it meets the requirements established by the laws of this state and provides for payment of at least eighty percent of the covered expenses required by

this section in excess of a deductible which does not exceed five hundred dollars per person. The coverage shall include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for sevices covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

3. A plan of health coverage shall be certified as a number one qualified plan A if it meets the requirements established by the laws of this state and provides for the payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed one thousand dollars per person. The coverage shall include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

SECTION 4. MINIMUM BENEFITS OF A QUALIFIED PLAN B.

1. A plan of health coverage shall be a number three qualified plan B if it otherwise meets requirements established by chapter 26-03.1, and the other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

   a. The minimum benefits for covered individuals shall, subject to the other provisions of this subdivision, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which does not exceed one hundred fifty dollars per person. The coverage shall include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

   b. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

      (1) Hospital services.

      (2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

      (3) Drugs requiring a physician's prescription.

(4) Services of a nursing home for not more than one hundred twenty days in a year if the services commence within fourteen days following confinement of at least three days in a hospital for the same condition.

(5) Service of a home health agency up to a maximum of one hundred eighty visits per year.

(6) Use of radium or other radioactive materials.

(7) Oxygen.

(8) Anesthetics.

(9) Prostheses.

(10) Rental or purchase, as appropriate, of durable medical equipment.

(11) Diagnostic X-rays and laboratory tests.

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(13) Services of a physical therapist.

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

c. Covered expenses shall also include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include the following:

(1) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which

benefits are payable under another policy of accident and sickness insurance or medicare.

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(3) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(7) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

2. A plan of health coverage shall be certified as a number two qualified plan B if it meets the requirements established by the laws of this state and provides for payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed five hundred dollars per person. The coverage shall include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

3. A plan of health coverage shall be certified as a number one qualified plan B if it meets the requirements established by the laws of this state and provides for the payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed one thousand dollars per person. The coverage shall include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1.

Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

SECTION 5. ASSOCIATION PLAN PREMIUM. The schedule of premiums to be charged eligible persons for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

SECTION 6. DUTIES OF COMMISSIONER. The commissioner shall:

1. Formulate general policies to advance the purposes of this Act and adopt rules pursuant to chapter 28-32 to carry out the provisions of this Act.

2. Supervise the creation of the comprehensive health association within the limits described in section 7.

3. Approve the association's contract with the lead carrier including the association plan coverage and premiums to be charged.

4. Conduct periodic audits to assure the general accuracy of the financial data submitted by the lead carrier and the association.

5. Undertake, directly or through contracts with other persons, studies or demonstration projects to develop awareness of the benefits of this Act so that the residents of this state may best avail themselves of the health care benefits provided by this Act.

SECTION 7. COMPREHENSIVE HEALTH ASSOCIATION.

1. There is established a comprehensive health association with participating membership consisting of those insurers, licensed or authorized to do business in this state, with an annual premium volume of accident and sickness insurance contracts, derived from or on behalf of residents in the previous calendar year, of at least one hundred thousand dollars, as determined by the commissioner.

2. The board of directors of the association shall be made up of ten individuals, one from each of the ten participating member insurers of the association with the highest annual premium volumes of accident and sickness insurance contracts as determined in subsection 1. Each board member shall be entitled to votes, in person or by proxy, based on the member's annual premium volume of accident and sickness insurance contracts as determined in subsection 1, in accordance with the following schedule:

$ 100,000	- 4,999,999	1 vote
$ 5,000,000	- 9,999,999	2 votes
$10,000,000	- 14,999,999	3 votes
$15,000,000 or more		4 votes

Members of the board may be reimbursed from the moneys of the association for expenses incurred by them due to their service as board members, but shall not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors shall be borne by participating members of the association.

3. All participating members shall enter into a contract of reinsurance with the association according to the terms specified in section 8. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. An insurance company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

4. All participating members shall maintain their membership in the association, as a condition for writing accident and sickness insurance policies as defined in this Act in this state.

5. The association shall submit bylaws and operating rules to the commissioner for approval.

6. The association may:

   a. Exercise the powers granted to insurers under the laws of this state.

   b. Sue or be sued.

   c. Enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions.

   d. Establish administrative and accounting procedures for the operation of the association.

   e. Provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association.

   f. Provide for the administration by the association of policies which are reinsured pursuant to subdivision e of this subsection.

SECTION 8. OPERATION OF COMPREHENSIVE PLAN.

1. Upon certification as an eligible person in the manner provided by section 11, an eligible person may enroll in the comprehensive health insurance plan by payment of the association plan premium to the lead carrier.

2. Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier shall be used to pay claims and not more than twelve and one-half percent shall be used for payment of the lead carrier's direct and indirect expenses as specified in section 10 of this Act.

3. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services shall be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

4. Each participating member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of individual reinsurance contracts executed by the association with each participating member in accordance with section 7 of this Act. Deviations in the total claims expense of the association plan from the premium payments allocated to the payment of benefits shall be the liability of association members. Association members shall share in the excess costs of the association plan in an amount equal to the ratio of a member's total annual premium volume for accident and sickness insurance charges, received from or on behalf of state residents, to the total accident and sickness insurance premium contract charges received by all association members from or on behalf of state residents, as determined by the commissioner. The reinsurance contracts shall provide for a retroactive determination of each member's liability and payment shall be due within thirty days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payments within thirty days of notification by the association shall be grounds for termination of membership.

SECTION 9. MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN. The association through its comprehensive health insurance plan shall offer policies which provide at least the benefits of a number one, two, and three qualified plan A and qualified plan B.

SECTION 10. ADMINISTRATION OF PLAN.

1. Any participating member of the association may submit to the commissioner the policies of accident and sickness insurance which are being proposed to serve as the

comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

2. Upon the commissioner's approval of the policy forms and contracts submitted, the association shall select policies and contracts by a member or members of the association to be the comprehensive health insurance plan. The association shall select one lead carrier to issue the qualified plans. The board of the directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier shall be based upon criteria established by the board of directors.

3. The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least three years, unless a request to terminate is approved by the association and the commissioner. The commissioner and the association shall approve or deny a request to terminate within ninety days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed an approval. Six months prior to the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the lead carrier. The association shall follow the provisions of subsection 2 in selecting a lead carrier for the subsequent three-year period, or if a request to terminate is approved on or before the end of the three-year period.

4. The lead carrier shall provide all eligible persons involved in the plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

5. The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the association plan.

6. All claims shall be paid by the lead carrier pursuant to the provisions of this Act and shall indicate that the claim was paid by the association plan. Each claim payment shall include information specifying the procedure

involved in the event a dispute over the amount of payment arises.

7. The lead carrier shall be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the association plan. The association shall approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

8. The lead carrier shall at all times, when carrying out its duties under this Act, be considered an agent of the association and the commissioner, and shall be civilly liable for its actions, subject to the laws of this state.

SECTION 11. ENROLLMENT BY ELIGIBLE PERSON.

1. The comprehensive health insurance plan shall be open for enrollment by eligible persons. A person is eligible and may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate shall provide the following:

   a. Name, address, and age of the applicant, and length of applicant's residence in this state.

   b. Name, address, and age of spouse and children, if any, if they are to be insured.

   c. Written evidence that the applicant has been rejected for accident and sickness insurance, or that restrictive riders or a preexisting conditions limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least two insurers within six months of the date of the certificate.

   d. A designation of coverage desired.

2. Within thirty days of receipt of the certificate of application, the lead carrier shall either reject the application for failing to comply with the requirements of subsection 1 or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's association plan premium, and shall be retroactive to the

date of application, if applicant otherwise complies with the requirements of this Act.

3. An eligible person may not purchase more than one policy from the association plan.

4. No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first six months of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the filing of an application. However, this subsection does not apply to a person who has had continuous coverage under a family or group accident and sickness insurance policy during the year immediately preceding the filing of an application.

SECTION 12. SOLICITATION OF ELIGIBLE PERSONS.

1. The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of a comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

2. The association shall devise and implement means of maintaining public awareness of the provisions of this Act and shall administer this Act in a manner which facilitates public participation in the association plan.

3. All licensed accident and sickness insurance agents may engage in the selling or marketing of qualified association plans. The lead carrier shall pay an agent's referral fee of twenty-five dollars to each licensed accident and sickness insurance agent who refers an applicant to the association plan, if the applicant is accepted. The referral fees shall be paid to the lead carrier from monies received as premiums for the association plan.

4. Every insurer which rejects or applies underwriting restrictions to an applicant for accident and sickness insurance shall notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it.

SECTION 13. EFFECTIVE DATE. Beginning January 1, 1982, the association shall make qualified comprehensive health insurance plans available to eligible persons as required by this Act.

Approved April 6, 1981

CHAPTER 309

HOUSE BILL NO. 1364
(Kloubec)

INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

AN ACT to create and enact a new chapter to the North Dakota Century Code, relating to the national association of insurance commissioners' model insurance holding company system regulatory act; and to repeal section 26-11-13 of the North Dakota Century Code, relating to special purpose corporations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. DEFINITIONS. As used in this chapter, the following terms shall have the respective meanings hereinafter set forth, unless the context otherwise requires:

1. An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

2. "Commissioner" is the insurance commissioner, his deputies, or the insurance department, as appropriate.

3. "Control", "controlling", "controlled by", and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided for in subsection 9 of section 4 of this Act, that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making

specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

4. An "insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.

5. "Insurer" shall have the same meaning as set forth in section 26-02-02, except that it shall not include:

   a. Agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

   b. Fraternal benefit societies.

   c. Nonprofit medical and hospital service associations.

6. A "person" is an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any securities broker performing no more than the usual and customary broker's function.

7. A "securityholder" of a specified person is one who owns any security of such person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

8. A "subsidiary" of a specified person is an affiliate controlled by such person directly, or indirectly through one or more intermediaries.

9. "Voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

SECTION 2. SUBSIDIARIES OF INSURERS - AUTHORIZATION - ADDITIONAL INVESTMENT AUTHORITY - EXEMPTION FROM INVESTMENT RESTRICTIONS - QUALIFICATION OF INVESTMENT - CESSATION OF CONTROL.

1. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

   a. Any kind of insurance business authorized by the jurisdiction in which it is incorporated.

b. Acting as an insurance broker or as insurance agent for its parent or for any of its parent's insurer subsidiaries.

c. Investing, reinvesting or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary.

d. Management of any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services.

e. Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended.

f. Rendering investment advice to governments, government agencies, corporations or other organizations or groups.

g. Rendering other services related to the operations of an insurance business including, but not limited to, actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services.

h. Ownership and management of assets which the parent corporation could itself own or manage.

i. Acting as administrative agent for a governmental instrumentality which is performing an insurance function.

j. Financing of insurance premiums, agents and other forms of consumer financing.

k. Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business.

l. Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

2. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections, a domestic insurer may also:

a. Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of five percent of such insurer's admitted assets or fifty percent of such insurer's surplus as regards

policyholders, provided that after such investments the insurer's surplus regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, there shall be included:

(1) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and

(2) All amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation.

b. If the insurer's total liabilities, as calculated for national association of insurance commissioners annual statement purposes, are less than ten percent of assets, invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, provided that after such investment the insurer's surplus as regards policyholders, considering such investment as if it were a disallowed asset, will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

c. Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries provided that each such subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subsection 1. For the purpose of this clause, "the total investment of the insurer" shall include:

(1) Any direct investment by the insurer in an asset, and

(2) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership of such subsidiary;

d. With the approval of the commissioner, invest any amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries, provided that after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

e. Invest any amount in the common stock, preferred stock, debt obligations, or other securities of any subsidiary exclusively engaged in holding title to and managing or developing real or personal property, if after considering as a disallowed asset so much of the investment as is represented by subsidiary assets which if held directly by the insurer would be considered as a disallowed asset, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, and if following such investment all voting securities of such subsidiary would be owned by the insurer.

3. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection 2 hereof shall not be subject to any of the otherwise applicable restrictions or prohibitions applicable to such investments of insurers.

4. Whether any investment pursuant to subsection 2 meets the applicable requirements thereof is to be determined immediately after such investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the date they were made.

5. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after such investment shall have been made, such investment shall have met the requirements for investment under any other section, and the insurer has notified the commissioner thereof.

SECTION 3. ACQUISITION OF CONTROL OF OR MERGER WITH DOMESTIC INSURER - FILING REQUIREMENTS - CONTENT OF STATEMENT - ALTERNATIVE FILING MATERIALS - APPROVAL BY COMMISSIONER - HEARINGS - MAILINGS TO SHAREHOLDERS - EXEMPTIONS - VIOLATIONS - JURISDICTION - CONSENT TO SERVICE OF PROCESS.

1. No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to

acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of such insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to such insurer, and such insurer has sent to its shareholders, a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner hereinafter prescribed. For purposes of this section, a domestic insurer shall include any other person controlling a domestic insurer unless such other person is either directly or through its affiliates primarily engaged in business other than the business of insurance.

2. The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following information:

a. The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection 1 is to be effected, hereinafter called the "acquiring party":

(1) If such person is an individual, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years; or

(2) If such person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by this subsection.

b. The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any

transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

c. Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety days prior to the filing of the statement.

d. Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

e. The number of shares of any security referred to in subsection 1 which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection 1, and a statement as to the method by which the fairness of the proposal was arrived at.

f. The amount of each class of any security referred to in subsection 1 which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

g. A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection 1 in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

h. A description of the purchase of any security referred to in subsection 1 during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor.

i. A description of any recommendations to purchase any security referred to in subsection 1 made during the twelve calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

j. Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection 1, and, if distributed, of additional soliciting material relating thereto.

k. The term of any agreement, contract or understanding made with any broker-dealer as to solicitation of securities referred to in subsection 1 for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

l. Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders and securityholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection 1 is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by subdivisions a through l shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection 1 is a corporation, the commissioner may require that the information called for by subdivisions a through l shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the commissioner and sent to such insurer within two business days after the person learns of such change. Such insurer shall send such amendment to its shareholders.

3. If any offer, request, invitation, agreement or acquisition referred to in subsection 1 is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection 1 may utilize such documents in furnishing the information called for by that statement.

4. The commissioner shall approve any merger or other acquisition of control referred to in subsection 1 unless, after a public hearing thereon, he finds that:

   a. After the change of control, the domestic insurer referred to in subsection 1 would not be able to satisfy the requirements for the issuance of a certificate of authority to write the line or lines of insurance for which it is presently licensed.

   b. The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein.

   c. The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders or the interests of any remaining securityholders who are unaffiliated with such acquiring party.

   d. The terms of the offer, request, invitation, agreement or acquisition referred to in subsection 1 are unfair and unreasonable to the securityholders of the insurer.

   e. The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest.

   f. The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control.

The public hearing referred to in subsection 4 shall be held within thirty days after the statement required by

subsection 1 is filed, and at least twenty days' notice thereof shall be given by the commissioner to the person filing the statement. Not less than seven days' notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The insurer shall give such notice to its securityholders. The commissioner shall make a determination within thirty days after the conclusion of such hearing. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in district court of this state. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearing.

5. All statements, amendments, or other material filed pursuant to subsection 1 or 2, and all notices of public hearings held pursuant to subsection 4, shall be mailed by the insurer to its shareholders within five business days after the insurer has received such statements, amendments, other material, or notices. The expenses of mailing shall be borne by the person making the filing. As security for the payment of such expenses, such person shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner.

6. The provisions of this section shall not apply to:

   a. Any offers, requests, invitations, agreements or acquisitions by the person referred to in subsection 1 of any voting security referred to in subsection 1 which, immediately prior to the consummation of such offer, request, invitation, agreement or acquisition, was not issued and outstanding.

   b. Any transaction which is subject to the provisions of chapter 26-20, dealing with the merger or consolidation of two or more insurers.

   c. Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt therefrom as:

      (1) Not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or

(2) As otherwise not comprehended within the purposes of this section.

7. The following shall be violations of this section:

a. The failure to file any statement, amendment, or other material required to be filed pursuant to subsections 1 or 2.

b. The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurer unless the commissioner has given his approval thereto.

8. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under this section, and over all actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all such lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to such person at his last known address.

SECTION 4. REGISTRATION OF INSURERS - INFORMATION AND FORM REQUIRED - MATERIALITY - AMENDMENTS - TERMINATION - CONSOLIDATED FILING - ALTERNATIVE REGISTRATION - EXEMPTIONS - DISCLAIMER - VIOLATIONS.

1. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section. Any insurer which is subject to registration under this section shall register within sixty days after the effective date of this chapter or fifteen days after it becomes subject to registration, whichever is later, unless the commissioner for good cause shown extends the time for registration, and then within such extended time. The commissioner may require any authorized insurer which is a member of a holding company system which is not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurance company with the insurance regulatory authority of domiciliary jurisdiction.

2. Every insurer subject to registration shall file a registration statement on a form provided by the commissioner, which shall contain current information about:

   a. The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer.

   b. The identity of every member of the insurance holding company system.

   c. The following agreements in force, relationships subsisting, and transactions currently outstanding between such insurer and its affiliates:

      (1) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

      (2) Purchases, sales, or exchange of assets;

      (3) Transactions not in the ordinary course of business;

      (4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

      (5) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles; and

      (6) Reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company.

   d. Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner.

3. No information need be disclosed on the registration statement filed pursuant to subsection 2 if such information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving one-half of one percent or less of an insurer's admitted assets as of the thirty-first day of December next

preceding shall not be deemed material for purposes of this section.

4. Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within fifteen days after the end of the month in which it learns of each such change or addition, provided, however, that subject to subsection 3 of section 5, each registered insurer shall so report all dividends and other distributions to shareholders within two business days following the declaration thereof.

5. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

6. The commissioner may require or allow two or more affiliated insurers subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

7. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection 1 to file all information and material required to be filed under this section.

8. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule, regulation, or order shall exempt the same from the provisions of this section.

9. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with such person unless and until the commissioner disallows such a disclaimer. The commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance.

10. The failure to file a registration statement or any amendment thereto required by this section within the time

specified for such filing shall be a violation of this section.

SECTION 5. STANDARDS - TRANSACTIONS WITH AFFILIATES - ADEQUACY OF SURPLUS - DIVIDENDS AND OTHER DISTRIBUTIONS.

1. Material transactions by registered insurers with their affiliates shall be subject to the following standards:

   a. The terms shall be fair and reasonable.

   b. The books, accounts and records of each party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions.

   c. The insurer's surplus as regards to policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

2. For purposes of this chapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

   a. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria.

   b. The extent to which the insurer's business is diversified among the several lines of insurance.

   c. The number and size of risks insured in each line of business.

   d. The extent of the geographical dispersion of the insurer's insured risks.

   e. The nature and extent of the insurer's reinsurance program.

   f. The quality, diversification, and liquidity of the insurer's investment portfolio.

   g. The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

   h. The surplus as regards policyholders maintained by other comparable insurers.

   i. The adequacy of the insurer's reserves.

j. The quality and liquidity of investments in subsidiaries made pursuant to section 2. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants.

3. No insurer subject to registration under section 4 shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

a. Thirty days after the commissioner has received notice of the declaration thereof and has not within such period disapproved such payment, or

b. The commissioner shall have approved such payment within such thirty-day period.

4. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the greater of:

a. Ten percent of such insurer's surplus as regards policyholders as of the thirty-first day of December next preceding, or

b. The net gain from operations of such insurer, if such insurer is a life insurer, or the net investment income, if such insurer is not a life insurer, for the twelve-month period ending the thirty-first day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

5. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until:

a. The commissioner has approved the payment of such dividend or distribution, or

b. The commissioner has not disapproved such payment within the thirty-day period referred to above.

SECTION 6. EXAMINATION - POWER OF COMMISSIONER - PURPOSE AND LIMITATION - USE OF CONSULTANTS - EXPENSES.

1. Subject to the limitations contained in this section and in addition to the powers which the commissioner has relating to the examination of insurers, the commissioner

shall also have the power to order any insurer registered under section 4 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as shall be necessary to ascertain the financial condition or legality of conduct of such insurer. In the event such insurer fails to comply with such order, the commissioner shall have the power to examine such affiliates to obtain such information.

2. The commissioner shall exercise his power under subsection 1 only if the examination of the insurer, under other provisions of the law, is inadequate or the interests of the policyholders of such insurer may be adversely affected.

3. The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsection 1. Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

4. Each registered insurer producing for examination records, books and papers pursuant to subsection 1 shall be liable for and shall pay the expense of such examination.

SECTION 7. CONFIDENTIAL TREATMENT. Any information, documents and copies thereof obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 6 and all information reported pursuant to section 4, shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the commissioner or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby, notice and opportunity to be heard, determines that the interests of policyholders, shareholders or the public will be served by the publication thereof, in which event he may publish all or any part thereof in such manner as he may deem appropriate.

SECTION 8. RULES AND REGULATIONS. The commissioner may issue such rules, regulations and orders as shall be necessary to carry out the provisions of this chapter.

SECTION 9. INJUNCTIONS - PROHIBITIONS AGAINST VOTING SECURITIES - SEQUESTRATION OF VOTING SECURITIES.

1. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this chapter or of any rule, regulation or order issued by the commissioner hereunder, the commissioner may apply to the

district court for the county in which the principal office of the insurer is located or if such insurer has no such office in this state then to the district court for Burleigh County for an order enjoining such insurer or such director, officer, employee or agent thereof from violating or continuing to violate this chapter or any such rule, regulation or order, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

2. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this article or of any rule, regulation or order issued by the commissioner hereunder may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding, but no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this chapter or of any rule, regulation or order issued by the commissioner hereunder, the insurer or the commissioner may apply to the district court for Burleigh County or to the district court for the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of section 3 or any rule, regulation, or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

3. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this chapter or any rule, regulation or order issued by the commissioner hereunder, the district court for Burleigh County or the district court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner seize or sequester any voting securities of the insurer owned directly or indirectly by such person, and issue such orders with respect thereto as may be appropriate to effectuate the provisions of this chapter.

4. Notwithstanding any other provisions of law, for the purposes of this chapter the sites of the ownership of the securities of domestic insurers shall be deemed to be in this state.

SECTION 10. CRIMINAL PROCEEDINGS. Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this chapter, the commissioner may cause criminal proceedings to be instituted by the district court for the county in which the principal office of the insurer is located or if such insurer has no such office in the state, then by the district court for Burleigh County against such insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this chapter may be fined not more than ten thousand dollars. Any individual who willfully violates this chapter may be fined not more than ten thousand dollars or, if such willful violation involves the deliberate perpetration of a fraud upon the commissioner, imprisoned not more than two years or both.

SECTION 11. RECEIVERSHIP. Whenever it appears to the commissioner that any person has committed a violation of this chapter which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the commissioner may proceed as provided in chapter 26-21 to take possession of the property of such domestic insurer and to conduct the business thereof.

SECTION 12. REVOCATION - SUSPENSION - NONRENEWAL OF INSURER'S LICENSE. Whenever it appears to the commissioner that any person has committed a violation of this chapter which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew such insurer's license or authority to do business in this state for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

SECTION 13. JUDICIAL REVIEW. Any person by any act, determination, rule, regulation, or order or any other action of the commissioner pursuant to this chapter may appeal therefrom as provided in chapter 28-32.

SECTION 14. REPEAL. Section 26-11-13 of the North Dakota Century Code is hereby repealed.

Approved March 5, 1981

CHAPTER 310

HOUSE BILL NO. 1070
(Legislative Council)
(Legislative Audit and Fiscal Review Committee)

FIRE AND TORNADO FUND NEW CONSTRUCTION RATE AND REINSURANCE LIMIT

AN ACT to amend and reenact subsection 2 of section 26-24-22 of the North Dakota Century Code, relating to the limit of reinsurance required by the state fire and tornado fund; and to repeal section 26-24-14 of the North Dakota Century Code, relating to the new construction insurance rate charged by the state fire and tornado fund on public property.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26-24-22 of the 1979 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. The limit of liability of such reinsurance contract shall be no less than ~~sixty~~ one hundred million dollars for each loss occurrence and ~~sixty~~ one hundred million dollars as respects all loss occurrences during each twelve-month period.

SECTION 2. REPEAL. Section 26-24-14 of the North Dakota Century Code is hereby repealed.

Approved February 18, 1981

CHAPTER 311

HOUSE BILL NO. 1415
(Representatives Wentz, Wagner)
(Senators Lips, Stenehjem)

NORTH DAKOTA PREPAID LEGAL SERVICES ACT

AN ACT to create and enact a new chapter to title 26 of the North Dakota Century Code, relating to the creation of the North Dakota Prepaid Legal Services Act, and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. SHORT TITLE. This Act may be cited as the "North Dakota Prepaid Legal Services Act".

SECTION 2. PURPOSES. This Act shall be interpreted liberally to achieve the following purposes:

1. To encourage the development of effective and economic methods for making legal services available to the public in this state.

2. To allow for the development of legal service plans and encourage experimentation with innovation methods of organizing and administering those plans.

3. To encourage competition among the various entities organized under this statute.

4. To insure maintenance of a high level of competence and adherence to professional standards.

SECTION 3. DEFINITIONS. As used in this Act:

1. "Commissioner" means the North Dakota commissioner of insurance.

2. "Evidence of coverage" means any certificate agreement or contract issued to a participant setting out the coverage to which the participant is entitled.

3. "Legal services" means any services normally provided by or at the direction of an attorney.

4. "Participant" means an individual who is enrolled in a prepaid legal services plan.

5. "Prepaid legal services organization" means any person who undertakes to provide an arrangement for one or more legal service plans.

6. "Prepaid legal services plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, reimburse or indemnify on a prepaid basis all or part of the cost of legal services and related expenses and court costs incurred in the exercise of any legal right, but not including payment of fines, penalties, judgments, or assessments.

7. "Provider" means any attorney licensed or otherwise authorized to practice law in this state.

SECTION 4. EXEMPTIONS. This Act shall not apply to:

1. Commercial insurers licensed or authorized to do business in this state or to any nonadmitted insurers.

2. Retainer contracts made by attorneys with individual clients with fees based upon an estimate of the nature and amount of services to be provided to a specific client and similar contracts made with a group of clients involved in the same or closely related legal matters.

3. Plans providing no benefits other than consultation with and advice by an attorney in connection or combination with referral services.

4. The furnishing of legal services on an informal basis, involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, educational, or similar relationship.

5. Employee welfare benefit plans as defined by the Employees Retirement Income Security Act of 1974.

SECTION 5. ESTABLISHMENT OF A PREPAID LEGAL SERVICES ORGANIZATION.

1. Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a prepaid legal services organization in compliance with this Act. No person shall establish or operate a prepaid legal services organization in this state, or sell, or offer to sell, or solicit offers to purchase or receive advance or periodic considerations in conjunction with a prepaid legal service plan without obtaining a certificate of authority under this Act. A foreign corporation may

similarly apply for a certificate of authority under this Act, subject to its registration to do business in this state as a foreign corporation under chapter 10-22.

2. Every prepaid legal services organization as of the effective date of this Act shall submit an application for a certificate of authority under subsection 3. Each such applicant may continue to operate until the commissioner acts upon the application. In the event an application is denied under section 6, the applicant shall be treated as a prepaid legal services organization whose certificate of authority has been revoked.

3. Applications for a certificate of authority must be made in a form prescribed by the commissioner and be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

   a. A copy of the basic organizational documents of the applicant, if any, including articles of incorporation, partnership agreements, trust agreements, or other applicable documents.

   b. A copy of the bylaws, regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

   c. A list of the names, addresses and official capacities within the organization of all persons who are responsible for the conduct of the affairs of the applicant, including all members of the governing body, the officers and directors in the case of a corporation, the partners under a partnership, the trustees under a trust agreement and the members or owners under any other organizational form.

   d. A statement generally describing the organization, its enrollment process, its administrative operations, any cost and quality control assurance mechanisms, its internal grievance procedure, the method it proposes to use to enroll members, the geographic area or areas to be served, the location of its office or offices, the number of providers to be utilized, and recordkeeping system which will provide documentation of the utilization of plan benefits by enrolled participants.

   e. A power of attorney duly executed by the applicant, if not domiciled in the state, appointing the commissioner and his successors in office and duly authorized deputies as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding

against the organization on a cause of action arising in this state may be served.

f. Copies of all contract forms the organization proposes to furnish to enrolled participants.

g. Copies of all contract forms the organization proposes to enter into with providers.

h. Copies of the forms evidencing coverage to be issued to enrolled participants.

i. Copies of the forms of group contracts, if any, which are to be issued to employers, unions, trustees, or other organizations.

j. A statement of the financial condition of the organization, including income statement, balance sheet and sources of funds.

k. A description of the proposed marketing techniques and copies of any proposed advertising materials.

l. A schedule of rates with any available actuarial and other data.

m. Other information required by the commissioner to make the determinations required under section 6.

SECTION 6. ISSUANCE OF A CERTIFICATE OF AUTHORITY. The commissioner shall issue a certificate of authority to any person filing an application within sixty days after the filing unless the commissioner notifies the applicant during that time that the application is not complete or sufficient and the reasons therefor, that payment of the fees required by section 16 has not been made or that the commissioner is not satisfied that:

1. The basic organizational documents of the applicant, when combined with the powers enumerated in section 7 permit the applicant to conduct business as a legal services organization.

2. The organization has demonstrated the intent and ability to provide the services in a manner which insures their availability and accessibility.

3. The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination the commissioner shall consider:

a. Any agreement with an insurer or any other organization paying, contracting to pay for or in any

way guarantying the provision of legal services under the plan.

b. Any agreement with the providers for the furnishing of legal services under the plan.

c. The adequacy of working capital.

d. Any surety bond or deposit of cash or securities as a guaranty that plan services will be performed.

SECTION 7. POWERS OF LEGAL SERVICES ORGANIZATION. The powers of a holder of a certificate of authority issued pursuant to section 5 shall, in addition to any other powers conferred by law, include the following:

1. The purchase, lease, construction, renovation, operation or maintenance of facilities and property reasonably required for the delivery of services or for such purposes as may be reasonably necessary to the operation of the organization.

2. The furnishing of legal services on a prepaid basis under agreements of indemnity with plan enrollees or under service contracts with providers who are under contract with, employed or otherwise associated with the legal services organization.

3. The marketing and administration of a legal service plan or plans, or contracting with any person for the performance of these functions on its behalf.

4. Contracting with an insurance company licensed or authorized to do business in this state for the provision of insurance, indemnity, or reimbursement against the cost of legal services provided by a legal services organization.

SECTION 8. CONTRACT FORMS.

1. All contracts or other documents evidencing coverage issued by the prepaid legal services organization to participants and marketing documents purporting to describe the organization's prepaid legal service plan shall contain:

a. A complete description of the legal services to which the participant is entitled.

b. The predetermined periodic rate of payment for legal services, if any, which the participant is obligated to pay.

c. All exclusions and limitations on services to be provided including any deductible or copayment feature and all restrictions relating to preexisting conditions.

d. All criteria by which a participant may be disenrolled or denied reenrollment.

2. No contract between a legal services organization authorized to do business under this Act and any provider or any participant shall contain any provisions which require participants to guaranty payment, other than copayments and deductibles, to the provider in the event of nonpayment by the legal services organization for any covered services which have been performed under contracts between the participant and the legal services organization.

3. No contract form or amendment shall be issued unless it is approved by the commissioner. The contract form or amendment shall be deemed approved after thirty days following its filing with the commissioner unless the commissioner finds during this period that the contract form or amendment does not comply with the requirements of section 6 or subsection 1 of this section.

SECTION 9. REPORTS TO THE COMMISSIONER.

1. Every legal services organization subject to this Act shall annually, on or before the first day of March, file a report with the commissioner, verified by an appropriate official of the organization, showing its financial condition on the last day of the preceding calendar or fiscal year.

2. The report shall include:

a. A financial statement of the organization, including its balance sheet and statement of income and expenditures for the preceding year prepared by an independent certified public accountant.

b. Any changes in the information submitted initially upon application for a certificate of authority under section 5.

c. Such other information relating to the performance of the organization as the commissioner requires to carry out his duties under this Act.

SECTION 10. COMPLAINT SYSTEM.

1. Every prepaid legal services organization shall establish and maintain a complaint system which has been approved by

the commissioner to provide reasonable procedures for the resolution of complaints initiated by participants concerning any aspect of the prepaid legal service plan or plans operated by the organization.

2. Each prepaid legal services organization shall submit to the commissioner an annual report in a form prescribed by the commissioner which shall include:

   a. A description of the procedure used under the complaint system;

   b. The total number of complaints by type handled through the complaint system; and

   c. Disposition of all complaints filed under the system.

3. The legal services organization shall maintain records of complaints, shall retain those records for a period of three years, and shall make those records available for inspection by the commissioner, provided, however, that no information regarding a participant or an attorney considered protected by the confidential nature of the attorney-client relationship may be divulged without written consent of the participant or upon appropriate court order.

4. Complaints alleging misfeasance, malfeasance or nonfeasance on the part of the attorneys or complaints alleging violations of the code of professional responsibility shall be submitted to the disciplinary board of the supreme court for disposition.

SECTION 11. PROHIBITED PRACTICES.

1. No prepaid legal services organization, or representative thereof, may cause or knowingly permit the use of advertising, solicitation or any form of coverage which is false, fraudulent, misleading or deceptive. For the purposes of this Act:

   a. A statement or item of information is deemed to be false if it does not conform to fact in any respect which is or may be significant to a participant, or a person considering participating in a legal service plan;

   b. A statement or item of information is deemed to be misleading, whether or not it may be literally untrue, if, in the context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding legal service of coverage, as indicating any

benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to a participant, or person considering participating in a legal services plan, if that benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

c. An evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format and language is such as to cause a reasonable person, not possessing special knowledge regarding legal service plans and evidence of coverage thereof, to expect benefits, services, or changes which the evidence of coverage does not provide or which the legal services plan issuing such evidence of coverage does not regularly make available for participants covered under the evidence of coverage.

2. A participant's coverage may not be canceled or nonrenewed except for the failure to pay the charge for that coverage, or for other reasons promulgated or approved by the commissioner.

3. No prepaid legal services organization may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or similar to the name or description of any insurance or surety corporation doing business in this state.

SECTION 12. LICENSING OF SALES REPRESENTATIVES. The sales representatives of any organization subject to the provisions of this chapter shall be subject to the laws pertaining to insurance agents as defined in chapter 26-17.1. The license or certification for the sales representatives shall be issued on a form as prescribed by the commissioner, and the fee therefor shall be three dollars.

SECTION 13. EXAMINATIONS.

1. The commissioner shall make an examination of the operations of any prepaid legal services organization holding a certificate of authority under this Act. The examination shall include all contracts, agreements, and arrangements for the delivery of services under the plan as often as the commissioner deems necessary, but not less frequently than once every three years.

2. The commissioner shall make an examination concerning the delivery of legal services of any prepaid legal services organization by reviewing any complaints made by participants brought against the organization or against

providers with whom the organization has contracts or other agreements as often as the commissioner deems necessary but not less frequently than once every three years.

3. Every legal services organization shall make its books and records relating to its operations available to the commissioner to facilitate the examination.

4. No examination of the commissioner may be undertaken which would violate the attorney-client privilege except with the written consent of the participant.

5. For the purpose of examination, the commissioner may issue subpoenas, administer oaths to, and examine the officers and agents of the legal services organization, as well as any providers of services.

SECTION 14. ADMINISTRATIVE FINDINGS AND SANCTIONS.

1. The commissioner, consistent with chapter 28-32, may initiate proceedings to determine if a legal service organization has:

   a. Operated in a manner that materially violates its organizational documents;

   b. Materially breached its obligations to furnish the legal services specified in its contracts with enrolled participants;

   c. Violated any provision of this Act, or any regulations promulgated hereunder;

   d. Made any false statement with respect to any report or statement required by this Act or by the commissioner under this Act;

   e. Advertised, marketed, or attempted to market its services in a manner which misrepresents its services or its capacity to deliver services, or engaged in deceptive, misleading, or unfair practices with respect to advertising or marketing; or

   f. Attempted to prevent the commissioner from the performance of any duty imposed by this Act or by other laws of this state.

2. After providing written notice and an opportunity for a hearing pursuant to chapter 28-32, the commissioner shall make administrative findings and, as appropriate, may:

a. Impose a penalty of not more than five thousand dollars for each unlawful act committed under this Act;

b. Issue an administrative order requiring the legal services organization to cease or modify inappropriate conduct or practices by it or any of the personnel employed by or associated with it, to fulfill its contractual obligations, to provide a service which has been improperly denied, or to take steps to provide or arrange for any services which it has agreed to make available; or

c. Suspend or revoke the certificate of authority of the legal services organization.

3. If its certificate of authority is suspended, the organization during the period of that suspension, shall not enroll any additional participants and shall not engage in any advertising or solicitation.

4. If its certificate of authority is revoked, the organization shall proceed under the supervision of the commissioner, immediately following the effective date of the revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of those affairs. The commissioner, by written order, may permit further operation of the organization if it is in the best interest of the participants and it will allow the participants the greatest practical opportunity to obtain continued legal services coverage.

5. The commissioner may apply to any court for the legal or equitable relief deemed necessary to carry out the purposes of this Act.

SECTION 15. STATE BAR ASSOCIATION - ADVISORY COMMITTEE.

1. Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the state bar association of North Dakota.

2. An advisory committee to assist the commissioner in the development of rules and regulations governing the conduct or organizations authorized under this Act is hereby created. The committee shall consist of seven members appointed by the board of governors of the state bar association of North Dakota. Members of the committee shall be allowed expenses for travel, board, and lodging in the performance of their duties as provided in sections 44-08-04 and 54-06-09. Members of the committee shall have the right to participate in any hearing held under

this Act, and shall receive notice of any order or decision of the commissioner.

SECTION 16. FEES. Every organization subject to this Act shall pay to the commissioner the following:

1. For filing a copy of its application for a certificate of authority or amendment thereto, the amount provided in subsection 3 of section 26-01-04.

2. For filing an annual report, the amount provided in subsection 2 of section 26-01-04.

3. The expenses of any examinations conducted pursuant to section 13.

SECTION 17. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS. Except as otherwise provided in this Act, provisions of the insurance laws of North Dakota shall not be applicable to any legal services organization granted a certificate of authority under this Act.

SECTION 18. IMPLEMENTING REGULATIONS. The commissioner after notice of hearing, may promulgate reasonable rules and regulations necessary and proper to carry out the provisions of this Act. Nothing in this Act shall be construed to prohibit the commissioner from requiring changes in procedure previously approved.

SECTION 19. CONTROL PROHIBITED. A prepaid legal services organization shall not attempt to control any attorney in the exercise of his or her professional judgment.

SECTION 20. SEVERABILITY. If any section, term, or provision of this Act shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this Act but the remaining sections, terms, and provisions shall be and remain in full force and effect.

Approved March 11, 1981

CHAPTER 312

SENATE BILL NO. 2061
(Legislative Council)
(Interim Health Care Committee)

HEALTH MAINTENANCE ORGANIZATIONS

AN ACT to create and enact a new section to chapters 26-38 and 54-52.1 of the North Dakota Century Code, relating to coordination of benefits provisions and authorizing the state employees retirement board to offer health maintenance organizations as optional health insurance coverage for state employees, and to create and enact a new subsection to section 54-52.1-01 of the North Dakota Century Code, relating to defining health maintenance organizations; to amend and reenact section 23-17.2-03, subsection 4 of section 26-38-03, section 26-38-06, subdivision d of subsection 2 of section 26-38-10, section 26-38-16, subsection 3 of section 26-38-17, sections 26-38-20 and 26-38-24, and subsection 3 of section 26-41-10 of the North Dakota Century Code, relating to facilities included for certificate of need laws, health maintenance organizations' applications for certificates of authority, review of applications for certificates of authority, evidence of coverage under a health care plan, open enrollment for health maintenance organizations, malpractice complaints, cancellation of health maintenance organization enrollees, acceptance of other health maintenance organization examinations, and coordination of benefits with basic no-fault benefits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

* SECTION 1. AMENDMENT. Section 23-17.2-03 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

23-17.2-03. FACILITIES INCLUDED - HEALTH MAINTENANCE ORGANIZATION EXCEPTION. Health care facilities and health care services ~~included~~ for the purpose of this chapter ~~shall~~ include health care facilities and health care services as defined in subsection 6 of section 23-17.2-02. However, health care facilities and health care services, for the purposes of this chapter, do not include health maintenance organizations, as defined in subsection 7 of section 26-38-01, when the health maintenance organization, or other entity, is engaged in activities to determine the feasibility

* NOTE: Section 23-17.2-03 was also amended by section 3 of House Bill No. 1204, chapter 286.

of developing and operating or expanding the operation of health maintenance organizations, or planning projects for the establishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by, health maintenance organizations, or initial development of health maintenance organizations. "Planning projects" and "initial development" mean those activities as defined in the "Health Maintenance Organization Act of 1973", as amended [Pub. L. 94-460, 90 Stat. 1948, 1950, 1955, and Pub. L. 95-559, 92 Stat. 2131, 2134; 42 U.S.C. 300 e-3].

SECTION 2. AMENDMENT. Subsection 4 of section 26-38-03 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

4. A copy of any contract made or to be made between any providers or persons listed in subsection 3 and the applicant. This subsection does not apply to contracts between individual providers, groups of providers, individual providers and groups of providers, or between other persons who are not applicants.

SECTION 3. AMENDMENT. Section 26-38-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-38-06. REVIEW OF APPLICATION BY COMMISSIONER - ISSUANCE OF CERTIFICATE OF AUTHORITY. The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 26-38-03 within ~~a--reasonable--length--of--time~~ ninety days following receipt of the certification from the state department of health. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed if the commissioner is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are honest, competent, and trustworthy.

2. The state department of health certifies, in accordance with section 26-38-05, that the health maintenance organization's proposed plan of operation meets the requirements of that section.

3. The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

4. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

a. The financial soundness of the health care plan's arrangements for health care services ~~and the schedule of charges used in connection therewith~~.

b. A schedule of premium rates with supporting actuarial and other data.

c. The adequacy of working capital.

~~c.~~ d. Any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan.

~~d.~~ e. Any agreement with providers for the provision of health care services. This subsection does not apply to agreements between individual providers, groups of providers, individual providers and groups of providers, or between other persons who are not applicants.

~~e.~~ f. Any surety bond or deposit of cash or securities submitted in accordance with section 26-38-19 as a guarantee that the obligations will be duly performed.

5. The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section 26-38-08.

6. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 26-38-03 or by independent investigation, is contrary to the public interest.

7. Any deficiencies certified by the state department of health have been corrected.

Denial of a certificate of authority shall be effective only after compliance with the requirements of section 26-38-28.

SECTION 4. AMENDMENT. Subdivision d of subsection 2 of section 26-38-10 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

d. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to an individual contract, and an indication whether the plan is contributory or noncontributory with respect to group ~~certificates~~ contracts.

SECTION 5. AMENDMENT. Section 26-38-16 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-38-16. OPEN ENROLLMENT - LIMITING MEMBERSHIP. After a health maintenance organization has been in operation ~~twenty-four months~~ five years, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose ~~such~~ any underwriting restrictions upon enrollment ~~as~~ which are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner shall approve or disapprove ~~such~~ the application within thirty days of ~~the~~ its receipt ~~thereof~~ from the health maintenance organization.

Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment ~~provided for herein~~ to all members of the group or groups covered or to be covered by ~~such~~ the contracts.

SECTION 6. AMENDMENT. Subsection 3 of section 26-38-17 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. The number, amount, and disposition of malpractice claims ~~settled~~ during the year filed by enrollees of the health maintenance organization against the health maintenance organization and any of the providers used by it.

SECTION 7. AMENDMENT. Section 26-38-20 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-38-20. PROHIBITED PRACTICES - ADVERTISING AND SOLICITATION - CANCELLATION OF ENROLLEES - NAME OF ORGANIZATION. No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For the purposes of this chapter:

1. A statement or item of information ~~shall be~~ is deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

2. A statement or item of information ~~shall be~~ is deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which ~~such~~ the statement is made or ~~such~~ the item of information is communicated, ~~such~~ the statement or item of information may be reasonably understood by a reasonable person, not possessing special

knowledge regarding health care coverage, ~~as indicating~~ to indicate the existence of any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if ~~such~~ the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

3. An evidence of coverage ~~shall be~~ is deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, ~~shall be such as to cause~~ causes a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage ~~therefor~~, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing ~~such~~ the evidence of coverage does not regularly make available to enrollees covered under ~~such~~ the evidence of coverage.

An enrollee may not be canceled or nonrenewed except for the failure to pay the proper ~~charge~~ premium for ~~such~~ coverage, actual or constructive fraud or flagrant abuse by the enrollee of the provisions of the health care plan, inability to maintain a therapeutic relationship with any of the health maintenance organization's primary care physicians, or for ~~such~~ other reasons as may be ~~promulgated~~ adopted by the commissioner.

No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

SECTION 8. AMENDMENT. Section 26-38-24 of the 1979 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-38-24. EXAMINATIONS BY COMMISSIONER AND STATE DEPARTMENT OF HEALTH - EXPENSES ASSESSED AGAINST ORGANIZATION - ~~EXAMINATION--BY OTHER STATES~~ ACCEPTANCE OF OTHER EXAMINATIONS. The commissioner may make an examination of the affairs of any health maintenance organization as often as he deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

The state department of health may make an examination concerning the quality of health care services of any health maintenance organization as often as it deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

For the purpose of examinations, the commissioner and the state department of health may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of providers with whom ~~such~~ the organization has contracts, agreements, or other arrangements pursuant to its health care plan. To the extent that ~~such~~ examinations may require the disclosure of personally identifying information relating to either financial transactions or medical information concerning a plan enrollee in the records of the health maintenance organization or the records of a provider with whom ~~such~~ the organization has contracts, agreements, or other arrangements pursuant to its health care plan, ~~such~~ the information is to be used for the sole purpose of assessing the quality of care provided and the degree of compliance with provisions of this chapter. ~~Such~~ The information is to be held in confidence and shall not be disclosed except upon the express consent of the enrollee, or pursuant to a court order for the production or discovery of evidence ~~or the discovery thereof~~, or in the event of a claim or litigation between the enrollee and the health maintenance organization ~~wherein such~~ when the information is pertinent.

The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner or the state department of health for whom the examination is being conducted.

~~In lieu of such examination, the~~ The commissioner or the state department of health may accept an examination or the report of an examination made by the commissioner or the state department of health of another state, the federal government, or ~~jurisdiction~~ an approved independent accrediting organization.

SECTION 9. A new section to chapter 26-38 of the North Dakota Century Code is hereby created and enacted to read as follows:

COORDINATION OF BENEFITS PROVISION. Group health maintenance organization contracts may contain coordination of benefits or other insurance provisions for the control of overinsurance. The provisions shall be in accordance with rules adopted by the commissioner.

SECTION 10. AMENDMENT. Subsection 3 of section 26-41-10 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. ~~Any~~ An insurer, health maintenance organization, or nonprofit service corporation, other than a basic no-fault insurer, authorized to do business in this state may coordinate any benefits it is obligated to pay for economic loss incurred as a result of accidental bodily injury, with the first five thousand dollars of basic no-fault benefits. ~~Any such~~ An insurer, health maintenance organization, or nonprofit service corporation may not coordinate benefits unless it provides those

persons who purchase benefits from it with an equitable reduction or savings in the direct or indirect cost of purchased benefits. ~~Any such~~ A coordination of benefits plan shall be approved by the commissioner of insurance.

SECTION 11. A new section to chapter 54-52.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

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. The contract or contracts shall be included in the uniform group insurance program.

SECTION 12. A new subsection to section 54-52.1-01 of the North Dakota Century Code is hereby created and enacted to read as follows:

"Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter 26-38.

Approved March 31, 1981

CHAPTER 313

SENATE BILL NO. 2070
(Legislative Council)
(Interim Judiciary "C" Committee)

"OWNER" DEFINED FOR NO-FAULT REQUIREMENTS

AN ACT to amend and reenact subsection 12 of section 26-41-03 of the North Dakota Century Code, relating to the definition of a motor vehicle owner for purposes of no-fault insurance requirements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 12 of section 26-41-03 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

12. "Owner" means the person in whose name the motor vehicle has been registered. If ownership has been transferred, but the registration record has not been changed, "owner" means the person, other than a lienholder, to whom ownership has been transferred. If no registration is in effect at the time of an accident involving the motor vehicle, "owner" means the person, other than a lienholder, who holds the legal title thereto~~, or in~~. In the event the motor vehicle is the subject of a security agreement ~~or~~ with the debtor having the right to possession, a lease with an option to purchase with the ~~debtor or~~ lessee having the right to possession, or a lease with a term of six months or more with the lessee having the right to possession, "owner" means the debtor or lessee.

Approved March 19, 1981