INSURANCE

CHAPTER 285

HOUSE BILL NO. 1169
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

FUNDS UNDER INSURANCE COMMISSIONER

AN ACT to create and enact a new section to chapter 299 of the 1991 Session Laws of North Dakota, relating to the petroleum tank release compensation fund; and to amend and reenact subsection 4 of section 26.1-21-01, subsection 5 of section 26.1-22-01, sections 26.1-22-06, and 26.1-22-21 of the North Dakota Century Code and section 20 of chapter 299 of the 1991 Session Laws of North Dakota, relating to the state bonding fund, petroleum tank release compensation fund, and fire and tornado fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 299 of the 1991 Session Laws of North Dakota is created and enacted as follows:

Investment of fund. Investment of the fund is under the supervision of the state investment board in accordance with chapter 21-10.

SECTION 2. AMENDMENT. Subsection 4 of section 26.1-21-01 of the North Dakota Century Code is amended and reenacted as follows:

4. "Political subdivision" means ~~a county, city, township, school district or park district, or any other unit of local government~~ all counties, townships, park districts, school districts, cities, and any other units of local government which are created either by statute or by the Constitution of North Dakota for local government or other public purposes.

SECTION 3. AMENDMENT. Subsection 5 of section 26.1-22-01 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

5. "Political subdivision" ~~includes a county, city, township, school district, or park district of this state~~ means all counties, townships, park districts, school districts, cities, and any other units of local government which are created either by statute or by the Constitution of North Dakota for local government or other public purposes.

SECTION 4. AMENDMENT. Section 26.1-22-06 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-22-06. Commissioner to adopt guidelines on insurable values. The commissioner shall adopt guidelines to be used by state agencies, departments, offices, officers, boards, commissions, international peace gardens, and winter shows for the purpose of determining insurable values of state-owned property and property belonging to an international peace garden or a winter show for insurance coverage as authorized by law. The commissioner shall adopt guidelines in

determining insurable values to assist state agencies and institutions and political subdivisions in determining whether to select indirect loss coverage. Notwithstanding any other provision of this chapter, the expenses for necessary loss prevention inspections and rating inspections for the purpose of determining the proper premium rate to be applied to the property insured by the fund must be paid out of the fund.

SECTION 5. AMENDMENT. Section 26.1-22-21 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-21. Insurance required - Excess loss reinsurance. The commissioner shall procure and shall keep in force, an excess loss reinsurance contract naming the fund as the reinsured. The reinsurance contract must meet the following minimum specifications:

1. Reimburse the fund for all losses in excess of one million dollars incurred by the fund under policies issued by the fund and arising out of each occurrence of a peril included in the fund policies.

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

3. A sixty-day cancellation notice.

4. The quoted rate must be the guaranteed rate for the two-year bid period.

The cost of the excess loss reinsurance must be paid out of the premium income of the fund. This excess loss reinsurance must be procured by the commissioner and the fund only through bids as hereinafter provided and must be written only by a company or companies authorized to do business within this state. The contract must be negotiated with and countersigned by a licensed North Dakota resident insurance agent. On or before the third Monday in June of each odd-numbered year the commissioner shall publish in the official newspaper of Burleigh County a notice that on the last Monday in June of that year the commissioner will accept bids at the commissioner's office in the state capitol. A copy of the notice must be posted at the office of the fund. A copy of the notice must be mailed to each insurance company licensed to write fire insurance in this state. On the last Monday in June of each odd-numbered year, the commissioner, with the approval of the industrial commission, shall contract for the excess loss reinsurance with the company or group of companies submitting the lowest and best bid for the two-year period commencing on the ensuing first day of August. The commissioner, with the approval of the industrial commission, may disregard this section after the commissioner and the commission have studied the available bids for the reinsurance required by this section.

SECTION 6. AMENDMENT. Section 20 of chapter 299 of the 1991 Session Laws of North Dakota is amended and reenacted as follows:

SECTION 20. Administrator to determine costs. A reimbursement may not be made from the fund until the administrator has determined that the costs for which reimbursement is requested were actually incurred and were reasonable. All necessary loss adjustment expenses must be included as a component of the loss and must be paid out of the fund.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 286

SENATE BILL NO. 2495
(Senators Mutch, Naaden)
(Representative Gorder)

PETROLEUM TANK DEFINITION

AN ACT to amend and reenact subsection 13 of section 2 of chapter 299 of the 1991 Session Laws of North Dakota, relating to the definition of "tank" for the purpose of the petroleum release compensation fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 13 of section 2 of chapter 299 of the 1991 Session Laws of North Dakota is amended and reenacted as follows:

13. "Tank" means any one or a combination of containers, vessels, and enclosures, whether aboveground or underground, including associated piping or appurtenances used to contain an accumulation of petroleum. The term does not include:

    a. Tanks owned by the federal government~~;~~.

    b. Tanks used for the transportation of petroleum~~; and~~.

    c. A pipeline facility, including gathering lines, regulated under:

        (1) The Natural Gas Pipeline Safety Act of 1968.

        (2) The Hazardous Liquid Pipeline Safety Act of 1979.

        (3) An interstate pipeline facility regulated under state laws comparable to the provisions of law in paragraph 1 or 2 of this subdivision.

    d. ~~A~~ An underground farm or residential tank with a capacity of one thousand one hundred gallons [4163.94 liters] or less or an aboveground farm or residential tank of any capacity used for storing motor fuel for noncommercial purposes. However, the owner of an aboveground farm or residential tank may, upon application, register the tank and be eligible for reimbursement under this Act.

    e. A tank used for storing heating oil for consumptive use on the premises where stored.

    f. A surface impoundment, pit, pond, or lagoon.

    g. A flowthrough process tank.

    h. A liquid trap or associated gathering lines directly related to oil or gas production or gathering operations.

i. A storage tank situated in an underground area such as a basement, cellar, mine working, drift, shaft, or tunnel if the storage tank is situated upon or above the surface of the floor.

j. A tank used for the storage of propane.

k. A tank used to fuel rail locomotives or surface coal mining equipment.

Approved March 25, 1993
Filed March 26, 1993

CHAPTER 287

HOUSE BILL NO. 1167
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE COMMISSIONER AUTHORITY

AN ACT to create and enact section 26.1-26-42.1 of the North Dakota Century Code, relating to revocation of nonresident license; and to amend and reenact sections 26.1-01-03.1 and 26.1-26-08 of the North Dakota Century Code, relating to cease and desist authority of the commissioner of insurance and licensing of partnerships or corporations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-01-03.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-03.1. Cease and desist authority - Hearing - Failure to appear. The commissioner may issue an order to cease and desist and notice of opportunity for hearing when it appears that any person is engaged in an act or practice which violates or may lead to a violation of this title. ~~The commissioner shall provide written notice to the person named in the order stating the time and place of the hearing on the matter and setting forth the alleged violation.~~ Any party aggrieved by the commissioner's order may make written application for a hearing on the order within thirty days of the date of the order. The application for a hearing must briefly state the respects in which the applicant is aggrieved by the order and the grounds for relief to be relied upon at the hearing. A hearing must be held not later than ten days after ~~the issuance of the order~~ an application for hearing is received unless a delay is requested by all persons named in the order. The commissioner shall, within thirty days after the ~~issuance of the cease and desist order~~ hearing, issue an order vacating the cease and desist order or making the cease and desist order permanent, as the facts require. The failure of any named person to appear at any proper hearing under this section after receiving notice of the hearing will cause that person to be in default and the allegations contained in the cease and desist order may be deemed to be true and may be used against the person at the hearing. If no civil monetary penalty is otherwise provided by law, the offender is, after hearing by the commissioner, subject to payment of an administrative monetary penalty of up to ten thousand dollars. If no hearing is requested by written application, the commissioner's order becomes permanent.

SECTION 2. AMENDMENT. Section 26.1-26-08 of the North Dakota Century Code is amended and reenacted as follows:

[1] **26.1-26-08. Licensing of partnership or corporation - Notice of change of individuals.** A partnership or corporation ~~may be licensed as~~ engaging in the

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[1] NOTE: Section 26.1-26-08 was also amended by section 29 of Senate Bill No. 2223, chapter 54.

activities of an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker must be licensed as such. Every member of the partnership and every officer, director, stockholder, and employee of the corporation personally engaged in this state in soliciting or negotiating policies of insurance must be registered with the commissioner, and each member, officer, director, stockholder, or employee must also be licensed. Within a reasonable time after the transfer of ownership of a partnership or corporation or after receipt of a properly completed application from a partnership or corporation for a license as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker, the commissioner may conduct investigations and propound interrogatories to satisfy the commissioner that the owners, stockholders, partners, or members of the partnership or corporation are competent, trustworthy, financially responsible, and of good personal and business reputation. The required license fee must be paid for the partnership or corporation and for each individual registered. The partnership or corporate licensee shall within ten business days notify the commissioner of every change relative to the individuals registered under the partnership or corporation. This section does not apply to a management association, partnership, or corporation whose operations do not entail the solicitation of insurance from the public. Every partnership or corporation subject to this section must be licensed by January 1, 1994.

SECTION 3. Section 26.1-26-42.1 of the North Dakota Century Code is created and enacted as follows:

26.1-26-42.1. Revocation of nonresident license. Nothwithstanding the provisions of subsection 13 of section 26.1-26-42, any nonresident license issued pursuant to this chapter may be suspended or revoked without notice and hearing to the licensee and without proceeding in conformity with chapter 28-32, upon evidence in the form of a certified copy that the authority which issued the resident license to the North Dakota nonresident licensee has revoked or suspended the resident license.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 288

HOUSE BILL NO. 1037
(Legislative Council)
(Interim Finance and Taxation Committee)

INSURANCE REPORTING OF FIRE DISTRICTS

AN ACT to require fire, allied lines, and multiple peril insurance applications to include a statement of the fire protection district in which the insured property is located; to provide a penalty; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Fire district maps - Insurance applications to show fire district in which property is located - Penalty. Before December first of each year, the commissioner of insurance shall publish maps of the fire districts of the state for use by insurers under this section for the following calendar year. The state firemen's association and the state fire marshal shall assist the commissioner of insurance in preparing the maps. After December 31, 1993, no insurer may issue or renew a policy for fire, allied lines, multiple peril crop, homeowner's multiple peril, farmowner's multiple peril, commercial multiple peril, or crop hail insurance coverage for property in this state unless the application identifies each fire district in which the insured property is located. The application must identify the property and insured value of the property located within each fire district if the policy provides coverage for property that is not all within a single district. For purposes of this section, "fire district" means rural fire protection district, city, or area served by a certified rural fire department. An insurer that is found by the commissioner to be in violation of this section is subject to a penalty of one hundred dollars for each such violation to be deposited in the insurance tax distribution fund. The commissioner of insurance may adopt rules necessary for administration of this section, including rules governing preparation, charges for, and use of maps under this section.

SECTION 2. APPROPRIATION. There is hereby appropriated out of any moneys in the insurance tax distribution fund in the state treasury, not otherwise appropriated, the sum of $10,000, or so much of the sum as may be necessary, to the commissioner of insurance for the purpose of creating maps of the fire districts in the state for use in reporting as provided in section 1 of this Act for the biennium beginning July 1, 1993, and ending June 30, 1995.

Approved March 15, 1993
Filed March 16, 1993

CHAPTER 289

HOUSE BILL NO. 1168
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE COMPANY FEES AND TAXES

AN ACT to amend and reenact section 26.1-02-02 and subsections 3 and 5 of section 26.1-03-17 of the North Dakota Century Code, relating to the penalty for failure of an insurance company to pay the renewal fee for a certificate of authority and to insurance premium tax credits, penalties, and refunds; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-02-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02-02. Duty of commissioner before granting or renewing certificate of authority. The commissioner must be satisfied by examination and evidence that an insurance company is legally qualified to transact business in this state, including compliance with section 26.1-03-11, before granting a certificate of authority to the company to issue policies or make insurance contracts. A certificate of authority issued under this title remains in force in perpetuity if the required renewal fee is paid by April thirtieth of each year and the commissioner is satisfied that the documents required by section 26.1-03-11 have been filed, the statements and evidences of investment required of the company have been furnished, the required capital or surplus or both, securities, and investments remain secure, and all other requirements of law are met. Any company which neglects to pay the renewal fee by April thirtieth forfeits twenty-five dollars for each day's neglect.

SECTION 2. AMENDMENT. Subsections 3 and 5 of section 26.1-03-17 of the 1991 Supplement to the North Dakota Century Code are amended and reenacted as follows:

3. Any person failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of five percent of the amount of tax due or one hundred dollars, whichever is greater, plus interest of one percent per month on the unpaid tax for each month or fraction of a month of delay, excepting the first day after the tax became due, or twenty-five dollars per day, whichever is greater. Any person failing to file the appropriate tax statement required by rule if the tax is zero is subject to a penalty of twenty-five dollars per day for each day's neglect not to exceed five hundred dollars. The commissioner, if satisfied that the delay was excusable, may waive, and if paid, issue a premium tax credit for all or any part of the penalty and interest.

5. If an amount of tax, penalty, or interest has been paid which was not due under the provisions of this section, ~~the amount of overpayment must be credited against any tax due, or to become due, under this section from~~ a refund may be issued to the taxpayer who made the erroneous payment. The refund is allowed as a credit against any tax due or to become due under

this section or as a cash refund, at the discretion of the commissioner. The taxpayer who made the erroneous payment shall present a claim for ~~credit~~ refund to the commissioner not later than two years after the due date of the return for the period for which the erroneous payment was made.

Approved April 14, 1993
Filed April 15, 1993

CHAPTER 290

SENATE BILL NO. 2456
(Senators Nalewaja, Jerome)
(Representatives Hokana, Timm)

REINSURANCE AND NONPROFIT HEALTH SERVICE CORPORATIONS

AN ACT to amend and reenact section 26.1-02-20, subsection 5 of section 26.1-17-05, and subsection 1 of section 26.1-31.2-01 of the North Dakota Century Code, relating to reinsurance, the authority of nonprofit health service corporations, and credit allowed a domestic ceding insurer; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-02-20 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02-20. Reinsurance permitted - Limitations. Except as otherwise provided by this section and section 26.1-02-22, any insurance company organized or admitted to transact business in this state, including a mutual company, may reinsure any part or all of any risk taken by it in any insurance company or insurer licensed in any state or any insurance company or insurer not so licensed or any nonprofit health service corporation whether or not licensed in this state provided it was approved or accepted by the commissioner, if that company or insurer or nonprofit health service corporation conforms to the same standards of solvency which would be required if, at the time the reinsurance is effected, it was licensed in this state. A county mutual insurance company also may reinsure with any other county mutual insurance company. No reinsurance, however, may be effected with any company disapproved therefor by written order of the commissioner filed in the commissioner's office. A domestic insurance company organized to engage in the business of life, accident, or health insurance may not reinsure its risks or any part thereof without complying with chapter 26.1-07.

[1] **SECTION 2. AMENDMENT.** Subsection 5 of section 26.1-17-05 of the North Dakota Century Code is amended and reenacted as follows:

5. Enter into contracts with other corporations, including insurance companies but only with prior approval of the insurance commissioner, or other entities in this state or in other states or possessions of the United States, or of the Dominion of Canada or other foreign countries so that:

   a. Reciprocity of benefits may be provided to subscribers.

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[1] NOTE: Section 26.1-17-05 was also amended by section 106 of Senate Bill No. 2223, chapter 54.

b. Transfer of subscribers from one entity to another may be effected to conform to the subscriber's place of residence.

c. Uniform benefits may be provided for all employees and dependents of such employees of entities and other organizations transacting business in this state and elsewhere and a rate representing the composite experience of the areas involved may be charged for such employees and their dependents.

d. Health services may be provided for subscribers or policyholders of this or other corporations, including insurers, or entities for the purpose of ceding or accepting reinsurance or of jointly providing benefits, underwriting, pooling, mutualization, equalization, and other joint undertakings which the governing board may from time to time approve.

SECTION 3. AMENDMENT. Subsection 1 of section 26.1-31.2-01 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. Credit must be allowed when the reinsurance is ceded to an assuming insurer or nonprofit health service corporation which is licensed to transact insurance or reinsurance in this state.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure.

Approved March 16, 1993
Filed March 16, 1993

CHAPTER 291

SENATE BILL NO. 2384
(Senator Lips)

INSURANCE FRAUD

AN ACT to define what constitutes insurance fraud, facilitate the detection of insurance fraud, allow reporting of suspected insurance fraud, grant immunity for reporting suspected insurance fraud, and require the restitution of fraudulently obtained insurance benefits; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in this chapter:

1. "Authorized agency" means any duly constituted criminal investigative department or agency of the United States or this state; the prosecuting attorney of any city, county, state, or of the United States or any subdivision thereof; or the commissioner of insurance.

2. "Financial loss" includes loss of earnings, out-of-pocket and other expenses, repair and replacement costs, and claims payments.

3. "Insurer" includes an authorized insurer, self-insurer, reinsurer, broker, producer, or any agent thereof.

4. "Person" means a natural person, company, corporation, unincorporated association, partnership, professional corporation, and any other legal entity.

5. "Practitioner" means a licensee of this state authorized to practice medicine and surgery, psychology, chiropractic, or law or any other licensee of the state whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in other states and nations or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

6. "Statement" includes any notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bills for services, diagnosis, prescription, hospital or doctor records, X-rays, test result, or other evidence of loss, injury, or expense.

SECTION 2. Insurance fraud. "Fraudulent insurance act" includes:

1. Acts or omissions committed by any person who knowingly, or with an intent to injure, defraud, or deceive:

   a. Presents or causes to be presented to an insurer, reinsurer, producer, broker, or any agent thereof, any oral or written statement knowing that the statement contains any false or misleading information concerning any fact material to an application for the issuance of an insurance policy;

b. Prepares or assists, abets, solicits, or conspires with another to prepare or make any oral or written statement that is intended to be presented to any insurer in connection with, or in support of, any application for the issuance of an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to the application;

c. Presents or causes to be presented to any insurer, any oral or written statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or thing material to such claims; or

d. Assists, abets, solicits, or conspires with another to prepare or make any oral or written statement, including computer-generated documents, which is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim.

2. The act of a practitioner who knowingly and willfully assists, conspires with, or urges any person to fraudulently violate any of the provisions of this chapter, or any person or practitioner who due to such assistance, conspiracy, or urging by said practitioner, knowingly and willfully benefits from the proceeds derived from the use of the fraud.

SECTION 3. Disclosure of information.

1. Upon request by an insurer to an authorized agency or by an authorized agency to an insurer, the insurer, an agent authorized by the insurer to act on its behalf, or the authorized agency may release to the authorized agency or the insurer any or all information that is deemed important relating to any suspected insurance fraud. This information may include:

   a. Insurance policy information relevant to investigation, including any application for such a policy.

   b. Policy premium payment records that are available.

   c. History of previous claims made by the insured.

   d. Information relating to the investigation of the suspected insurance fraud, including statements of any person, proofs of loss, and notice of loss.

2. a. When an insurer knows or reasonably believes it knows the identity of a person whom it has reason to believe committed a fraudulent insurance act or has knowledge of a suspected fraudulent insurance act that is reasonably believed not to have been reported to an authorized agency, then for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf may notify an authorized agency of the knowledge or belief and provide any additional information in accordance with subsection 1.

b. An insurer providing information to an authorized agency pursuant to subdivision a has the right to request in writing information in the possession or control of the authorized agency relating to the same suspected fraudulent insurance act of which the insurer notifies the authorized agency under subdivision a. The authorized agency shall provide the requested information within thirty days of the request.

3. In addition to providing information to an insurer under subdivision a of subsection 2, the authorized agency provided with information pursuant to subsections 1 and 2 may release or provide the information to any other authorized agency.

4. Except as otherwise provided by law, any information furnished pursuant to this section is privileged and not a part of any public record. The evidence or information is not subject to subpoena duces tecum in a civil or criminal proceeding unless, after reasonable notice to any insurer, agent, and authorized agency which has an interest in the information, and a subsequent hearing, a court determines that the public interest and any ongoing investigation will not be jeopardized by obeyance of the subpoena or subpoena duces tecum.

SECTION 4. Immunity.

1. A person when acting without malice is not subject to liability by virtue of filing reports, or furnishing orally or in writing other information concerning any suspected, anticipated, or completed fraudulent insurance act, when the reports or information are provided to or received from any authorized agency, the national association of insurance commissioners, or any other not-for-profit organization established to detect and prevent insurance fraud, and their agents, employees, or designees.

2. Except in prosecution for perjury or insurance fraud, and in the absence of malice, an insurer, or any officer, employee, or agent thereof, or any licensed producer or private person who cooperates with, furnishes evidence, or provides or receives information regarding any suspected fraudulent insurance act to or from an authorized agency, the national association of insurance commissioners, or any not-for-profit organization established to detect and prevent fraudulent insurance acts or who complies with an order issued by a court of competent jurisdiction acting in response to a request by any of these entities to provide evidence or testimony is not subject to a criminal proceeding or to a civil penalty with respect to any act concerning which the person testifies to or produces relevant matter.

3. In the absence of malice, an insurer, or any officer, employee, or agent thereof, or any licensed producer or private person who cooperates with, furnishes evidence, or provides information regarding any suspected fraudulent insurance act to an authorized agency, the national association of insurance commissioners, or any not-for-profit organization established to detect and prevent fraudulent insurance acts or who complies with an order issued by a court of competent jurisdiction acting in response to a request by any of these entities to furnish evidence or provide testimony, is not subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature exists against

the person, for filing reports, providing information, or otherwise cooperating with an investigation or examination of any of these entities.

4. The authorized agency, the national association of insurance commissioners, or any not-for-profit organization established to detect and prevent fraudulent insurance acts and any employee or agent of any of these entities, when acting without malice is not subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature will lie against the person by virtue of the execution of official activities or duties of the entity by virtue of the publication of any report or bulletin related to the official activities or duties of the entity.

5. This section does not abrogate or modify in any way common law or statutory privilege or immunity heretofore enjoyed by any person or entity.

SECTION 5. Penalties - Probation - Restitution.

1. A violation of section 2 of this Act is a class C felony if the value of any property or services retained exceeds five thousand dollars and a class A misdemeanor in all other cases. For purposes of this section, the value of any property and services must be determined in accordance with subsection 6 of section 12.1-23-05.

2. In the event that a practitioner is adjudicated guilty of a violation of section 2 of this Act, the court shall notify the appropriate licensing authority of this state of the adjudication. The appropriate licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against the practitioner.

3. Probation may not be granted to, nor may the imposition of a sentence be suspended, after the first adult conviction for a violation under section 2 of this Act and any subsequent conviction of the same.

4. The existence of any fact that would make a person ineligible for probation under this section must be alleged in the information or indictment, and:

   a. Admitted by the defendant in open court;

   b. Determined to be true at trial by a jury or the court; or

   c. By plea of guilty or nolo contendere.

5. In addition to any other punishment, a person who violates section 2 of this Act, must be ordered to make restitution to the insurer or to any other person for any financial loss sustained as a result of the violation of section 2 of this Act. The court shall determine the extent and method of restitution.

Approved April 28, 1993
Filed April 30, 1993

CHAPTER 292

SENATE BILL NO. 2231
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE LAW REVISIONS

AN ACT to create and enact sections 26.1-03-02.1, 26.1-03-19.1, 26.1-03-19.2, 26.1-03-19.3, 26.1-03-19.4, 26.1-03-19.5, 26.1-03-19.6, 26.1-03-19.7, chapter 26.1-06.2, a new section to chapter 26.1-10, a new subdivision to subsection 6 of section 26.1-10-05, chapter 26.1-18.1, a new subsection to section 26.1-26.3-06, chapter 26.1-26.5, a new subsection to section 26.1-31.1-02, section 26.1-35-01.1, a new subsection to section 26.1-46-01, two new subdivisions to subsection 7 of section 26.1-46-01, a new subdivision to subsection 3 of section 26.1-46-03, two new subsections to section 26.1-46-03, and section 26.1-46-08.1 of the North Dakota Century Code, relating to valuation of securities, examinations, administrative supervision, health maintenance organizations, managing general agents, business transacted with insurance broker controlled property and casualty insurer, reinsurance intermediaries, standard valuation law, and formation and operation of risk retention groups and purchasing groups; to amend and reenact section 26.1-05-04, subsection 5 of section 26.1-10-03, subsections 1, 2, 3, and 4 of section 26.1-10-04, subsection 8 of section 26.1-10-05, sections 26.1-12-08, 26.1-12-10, subsection 3 of section 26.1-26.3-01, subsection 6 of section 26.1-26.3-03, section 26.1-26.3-06, subdivision c of subsection 8 of section 26.1-31.1-01, subsection 1 of section 26.1-31.1-06, subsection 6 of section 26.1-31.1-07, section 26.1-31.1-10, subdivision d of subsection 2 of section 26.1-31.2-01, subdivisions b and d of subsection 4 of section 26.1-31.2-01, subsection 2 of section 26.1-31.2-02, sections 26.1-35-07, 26.1-35-08, subdivisions a and e of subsection 7 of section 26.1-46-01, subsection 10 of section 26.1-46-01, section 26.1-46-02, subsection 1 of section 26.1-46-03, sections 26.1-46-04, 26.1-46-06, 26.1-46-07, 26.1-46-08, and 26.1-46-09 of the North Dakota Century Code, relating to domestic companies, insurance holding company systems, mutual life companies, managing general agents, reinsurance intermediaries, reinsurance credit, standard valuation law, and formation and operation of risk retention groups and purchasing groups; and to repeal sections 26.1-03-02, 26.1-03-19, 26.1-03-20, 26.1-03-21, 26.1-12-17, chapters 26.1-18, and 26.1-26.2 of the North Dakota Century Code, relating to valuation of securities held by a company, financial examinations, risk limitations of mutual insurance companies, mutual insurance companies, health maintenance organizations, and business transacted with insurance broker controlled property and casualty insurer.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-03-02.1 of the North Dakota Century Code is created and enacted as follows:

26.1-03-02.1. Valuation of securities and other investments.

1. All securities and investments of insurance companies must be valued in accordance with published valuation standards of the national association of insurance commissioners including, but not limited to, the accounting practices and procedure manuals and publications by the valuation of securities office of the national association of insurance commissioners.

2. All investments of insurance companies authorized to do business in this state, for which no method of valuation has been otherwise provided, must be valued in the discretion of the commissioner at their fair market value, appraised value, or at amounts determined by the commissioner as their fair market value. If any valuation of an investment by an insurer appears to be an unreasonable estimate of its true value, the commissioner has the authority to cause the investment to be appraised, and the appraised value must be substituted as the true value. The appraisal must be made by two disinterested and competent persons, one to be appointed by the commissioner and one to be appointed by the insurer. In the event these two persons fail to agree, they shall appoint a third disinterested and competent person, and the estimate of the value of the investment, as arrived at by these three persons, must be substituted as the true value.

SECTION 2. Section 26.1-03-19.1 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.1. Examination of companies - Definitions. In sections 26.1-03-19.1 through 26.1-03-19.7, unless the context otherwise requires:

1. "Company" means any foreign or domestic insurance company as defined in section 26.1-02-01.

2. "Examiner" means any individual or firm having been authorized by the commissioner to conduct an examination under this chapter.

3. "Person" means any individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

SECTION 3. Section 26.1-03-19.2 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.2. Authority, scope, and scheduling of examinations.

1. The commissioner or any of the commissioner's examiners may conduct an examination under this chapter of any company whenever the commissioner in the commissioner's sole discretion deems appropriate but shall at a minimum, conduct an examination of every insurer licensed in this state not less frequently than once every five years. In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider the matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the examiners' financial condition and market conduct handbook adopted by the national association of insurance commissioners and in effect when the commissioner exercises discretion under this section.

2. For purposes of completing an examination of any company under this chapter, the commissioner may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

3. In lieu of an examination under this chapter of any foreign insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, the reports may only be accepted if the insurance department was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program, or the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

SECTION 4. Section 26.1-03-19.3 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.3. Conduct of examinations.

1. Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue a letter appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the national association of insurance commissioners. The commissioner may also employ other guidelines or procedures as the commissioner may deem appropriate.

2. For the purposes of making any examination required or authorized by law, every company or person from whom information is sought, its officers, directors, trustees, and agents must provide to the examiners appointed under subsection 1, in any examination required or authorized by law, timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, trustees, and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, trustees, or agents to submit to examination or to comply with any reasonable request of the examiners is grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority must be conducted pursuant to sections 26.1-01-03.1 and 26.1-11-09.

3. The commissioner or any of the commissioner's examiners have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

4. Qualified regular employees of the commissioner, or the commissioner's designated representatives acting as independent contract examiners under the direction of regular employees of the commissioner, shall conduct all examinations of an insurance company required or permitted by law to be conducted by the commissioner, whether or not the examinations are convention examinations called in accordance with rules promulgated by the national association of insurance commissioners. The commissioner may contract for and procure the services of financial and market conduct examiners and other or additional specialized technical or professional assistants, as independent contractors. None of the persons providing those services or assistance on a contract or fee basis may be in the classified service of the state.

5. Nothing contained in this chapter may be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination will be prima facie evidence in any legal or regulatory action by and before the commissioner of insurance.

6. Except as provided in subsections 5 and 6 of section 26.1-03-19.4, nothing contained in this chapter may be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in the commissioner's sole discretion, deem appropriate.

SECTION 5. Section 26.1-03-19.4 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.4. Examination reports.

1. All examination reports must be comprised of only facts appearing upon the books, records, or other documents of the company, its agents, or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and the conclusions and recommendations as the examiners find reasonably warranted from the facts.

2. No later than sixty days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together

with a notice which must afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

3. Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and enter an order:

   a. Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation;

   b. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to subsection 1 above; or

   c. Calling for an investigatory hearing with no less than twenty days notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

4. a. All orders entered pursuant to subdivision a of subsection 3, except those entered pursuant to section 26.1-01-03.1 or 26.1-11-09, must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. The company may, within thirty days of the entry of any such order, request a hearing to vacate or amend the order. This hearing must be conducted in compliance with chapter 28-32. The order must be served upon the company, together with a copy of the adopted examination report. Within thirty days of the issuance of the adopted report, the company shall acknowledge receipt of the adopted report and related orders.

   b. Any hearing conducted under subdivision c of subsection 3 by the commissioner or authorized representative must be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within twenty days of the conclusion of any hearing, the commissioner shall enter an order pursuant to subdivision a of subsection 3.

5. a. Upon the adoption of a financial examination report under subdivision a of subsection 3, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of fifteen days except to the extent provided in subsection 2. Thereafter, the commissioner may open the report for

public inspection so long as no court of competent jurisdiction has stayed its publication.

b. Nothing contained in this code prevents or may be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report, or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this chapter.

c. In the event the commissioner determines that regulatory action is appropriate as a result of any examination, the commissioner may initiate any proceedings or actions as provided by law.

6. a. All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of a financial examination made under this chapter must be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent provided in subsection 5. Access may also be granted to the national association of insurance commissioners. The parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

b. For purposes of any other examination other than financial examinations required or authorized by law, all preliminary data, drafts, notes, impressions, memoranda, working papers, and work product generated by the commissioner or the person making an examination or inspection are confidential and not open for public inspection until the commissioner releases a final report concerning the examination or inspection or upon a declaration by the commissioner that the material is nonconfidential. If a declaration of nonconfidentiality is requested by any person and denied, the commissioner, in the denial, shall state the reason for the confidentiality and the date, as can best be reasonably determined at the time, when it will be made public.

SECTION 6. Section 26.1-03-19.5 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.5. Conflict of interest. No examiner may be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This section must not be construed to automatically preclude an examiner from being:

1. A policyholder or claimant under an insurance policy.

2. A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business.

3. An investment owner in shares of regulated diversified investment companies.

4. A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

Notwithstanding the requirements of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

SECTION 7. Section 26.1-03-19.6 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.6. Cost of examinations. For purposes of any examination authorized or required by law, the company being examined shall pay the same charge for the examination as is provided in section 26.1-01-07 for an official examination. The compensation to be paid to the employees of the commissioner is to be paid out of the appropriation for the commissioner's office. Any sums paid to the employees or to the commissioner by the company examined, as an examination fee or otherwise, is state money, and forthwith must be paid into the insurance regulatory trust fund. Any sums paid to the employee or the commissioner as expense money for the examiner may be paid directly to the employee, and no employee may charge or collect from the state any expenses incurred in connection with any examination for or during which expenses or any part thereof have been paid by any other person, firm, or corporation. However, the compensation and expenses paid for independent contract examiners must be paid directly by the company examined after approval by the commissioner.

SECTION 8. Section 26.1-03-19.7 of the North Dakota Century Code is created and enacted as follows:

26.1-03-19.7. Immunity from liability.

1. No cause of action arises, nor may any liability be imposed, against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

2. No cause of action arises, nor may any liability be imposed, against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

3. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection 1.

4. A person identified in subsection 1 is entitled to an award of attorney's fees and costs if that person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

SECTION 9. AMENDMENT. Section 26.1-05-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-05-04. Capital stock and surplus requirements of domestic stock company - Exceptions. A stock insurance company may not be incorporated under this chapter unless it has an authorized capital stock of at least five hundred thousand dollars and a surplus of at least five hundred thousand dollars. A domestic stock insurance company may not issue any insurance policy until at least fifty percent of the required capital stock, and all of the required surplus, has been paid in, the residue of capital stock to be paid in within twelve months from the time of filing the articles of incorporation. The commissioner, for good cause shown, may extend the time of payment of the residue for the further period of one year. If the minimum capital stock and surplus requirements at the time a stock insurance company incorporated under this chapter were less than the minimum requirements provided by this section, the stock insurance company shall increase its authorized and paid in capital stock and surplus to ~~a minimum of two hundred fifty thousand dollars.~~ the minimum requirements under this section according to the following schedule:

1. Capital of two hundred fifty thousand dollars and surplus of two hundred fifty thousand dollars by December 31, 1994.

2. Capital of three hundred seventy-five thousand dollars and surplus of three hundred seventy-five thousand dollars by December 31, 1995.

3. Capital of five hundred thousand dollars and surplus of five hundred thousand dollars by December 31, 1996.

Except as otherwise provided in this section, the total value of paid-in capital stock and surplus of a stock insurance company organized under the laws of this state may not at any time be depleted to an amount totaling less than one million dollars.

SECTION 10. Chapter 26.1-06.2 of the North Dakota Century Code is created and enacted as follows:

26.1-06.2-01. Definitions. As used in this chapter:

1. "Consent" means agreement to administrative supervision by the insurer.

2. "Exceeded its powers" means any of the following conditions:

   a. The insurer has refused to permit examination of its books, papers, accounts, records, or affairs by the commissioner, the commissioner's deputies, employees, or duly commissioned examiners.

   b. A domestic insurer has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer.

c. The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto.

d. The insurer has neglected or refused to observe an order of the commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock, or surplus.

e. The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner.

f. The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the commissioner or has without first having obtained written approval of the commissioner, if approval is required by law, totally reinsured its entire outstanding business, or merged or consolidated substantially its entire property or business with another insurer.

g. The insurer engaged in any transaction in which it is not authorized to engage under the laws of this state.

h. The insurer refused to comply with a lawful order of the commissioner.

3. "Insurer" means and includes every person engaged as indemnity, surety, or contractor in the business of insurance or of annuities. For purposes of this chapter, any other persons included under section 26.1-06.1-02 must be deemed to be insurers.

26.1-06.2-02. Scope. The provisions of this chapter apply to:

1. All domestic insurers.

2. Any other insurer doing business in this state whose state of domicile has asked the commissioner to apply the provisions of this chapter as regards such insurer.

26.1-06.2-03. Notice to comply with written requirements of commissioner - Noncompliance - Administrative supervision.

1. An insurer may be subject to administrative supervision by the commissioner if upon examination or at any other time it appears in the commissioner's discretion that:

a. The insurer's condition renders the continuance of its business hazardous to the public or to its insureds.

b. The insurer appears to have exceeded its powers granted under its certificate of authority and applicable law.

c. The insurer has failed to comply with the applicable provisions of this title.

d. The business of the insurer is being conducted fraudulently.

e. The insurer gives its consent.

2. If the commissioner determines that the conditions set forth in subsection 1 exist, the commissioner shall:

   a. Notify the insurer of the commissioner's determination.

   b. Furnish to the insurer a written list of the requirements to abate this determination.

   c. Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of the chapter. The action by the commissioner is subject to review pursuant to chapter 28-32.

3. If placed under administrative supervision, the insurer has sixty days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of this chapter.

4. If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the end of the supervision period specified above, the commissioner may extend the supervision period.

5. If it is determined that none of the conditions giving rise to the supervision exist, the commissioner shall release the insurer from supervision.

26.1-06.2-04. Confidentiality of certain proceedings and records.

1. Notwithstanding any other provision of law and except as set forth in this section, proceedings, hearings, notices, correspondence, reports, records, and other information in the possession of the commissioner or the department relating to the supervision of any insurer are confidential.

2. The personnel of the department shall have access to these proceedings, hearings, notices, correspondence, reports, records, or information as permitted by the commissioner.

3. The commissioner may open the proceedings or hearings or disclose the notices, correspondence, reports, records, or information to a department, agency, or instrumentality of this or another state or the United States if the commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state or the United States.

4. The commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records, or other information if the commissioner deems that it is in the best interest of the public or in the best interest of the insurer, its insureds, creditors, or the general public.

5. This section does not apply to hearings, notices, correspondence, reports, records, or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction.

26.1-06.2-05. Prohibited acts during period of suspension. During the period of supervision, the commissioner or the commissioner's designated appointee

shall serve as the administrative supervisor. The commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of the commissioner or the commissioner's appointed supervisor:

1. Dispose of, convey, or encumber any of its assets or its business in force.
2. Withdraw any of its bank accounts.
3. Lend any of its funds.
4. Invest any of its funds.
5. Transfer any of its property.
6. Incur any debt, obligation, or liability.
7. Merge or consolidate with another company.
8. Approve new premiums or renew any policies.
9. Enter into any new reinsurance contract or treaty.
10. Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due.
11. Release, pay, or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate, or contract.
12. Make any material change in management.
13. Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends, or other payments deemed preferential.

26.1-06.2-06. Review and stay of action. During the period of supervision the insurer may contest an action taken or proposed to be taken by the supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration entitles the insurer to request a proceeding under chapter 28-32.

26.1-06.2-07. Administrative election of proceedings. Nothing contained in this chapter precludes the commissioner from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation proceedings or other delinquency proceedings, however designated under the laws of this state, regardless of whether the commissioner has previously initiated administrative supervision proceedings under this chapter against the insurer.

26.1-06.2-08. Rules. The commissioner may adopt reasonable rules necessary for the implementation of this chapter.

26.1-06.2-09. Other laws - Conflicts - Meetings between the commissioner and the supervisor. Notwithstanding any other provision of law, the commissioner may meet with a supervisor appointed under this chapter and with the attorney or other representative of the supervisor, without the presence of any other person, at the

time of any proceeding or during the pendency of any proceeding held under authority of this chapter to carry out the commissioner's duties under this chapter or for the supervisor to carry out the duties under this chapter.

26.1-06.2-10. Immunity. There is no liability on the part of, and no cause of action of any nature may arise against, the commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

SECTION 11. A new section to chapter 26.1-10 of the North Dakota Century Code is created and enacted as follows:

Dividends and other distribution.

1. The board of directors of any company subject to this chapter may declare and the company may pay dividends and other distributions on its outstanding shares and cash, property, or its own shares and on its treasury stock in its own shares, subject to the following provisions:

   a. No dividend or other distribution may be declared or paid at any time except out of earned, as distinguished from contributed, surplus, nor when the surplus of the company is less than the surplus required by law for the kind or kinds of business authorized to be transacted by such company, nor when the payment of a dividend or other distribution would reduce its surplus to less than such amount.

   b. Except in the case of share dividends, surplus for determining whether dividends or other distributions may be declared may not include surplus arising from unrealized appreciation in value, or revaluation of assets, or from unrealized profits upon investments.

   c. No dividend or other distribution may be declared or paid contrary to any restriction contained in the articles of incorporation.

   d. No dividend or other distribution may be declared or paid contrary to section 26.1-10-05.

2. No payment may be made to policyholders by way of dividends unless the company possesses admitted assets in the amount of such payment in excess of its capital, minimum required surplus, and all liabilities.

SECTION 12. AMENDMENT. Subsection 5 of section 26.1-10-03 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

5. This section does 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 26.1-07, dealing with the merger or consolidation of two or more insurance companies.

~~c.~~ b. Any offer, request, invitation, agreement, or acquisition which the commissioner by order has excepted 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 insurance company; or

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

SECTION 13. AMENDMENT. Subsections 1, 2, 3, and 4 of section 26.1-10-04 of the 1991 Supplement to the North Dakota Century Code are amended and reenacted as follows:

1. Every insurance company 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 insurance company subject to disclosure requirements and standards adopted by statute or rule in the jurisdiction of its domicile which are substantially similar to those contained in this section and section 26.1-10-05. Any insurance company subject to registration under this section shall register before August 31, 1981, or fifteen days after it becomes subject to registration, whichever is later, and annually thereafter by March first of each year for the previous calendar year unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any authorized insurance company which is a member of a holding company system not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority of the domiciliary jurisdiction.

2. Every insurance company subject to registration shall file a registration statement on a form approved by the commissioner, which must contain current information about:

   a. The capital structure, general financial condition, ownership, and management of the insurance company and any person in control of the insurance company.

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

   c. The following agreements in force, relationships subsisting, and transactions currently outstanding or which have occurred during the last calendar year between the insurance company and its affiliates:

      (1) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurance company or of the insurance company 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 insurance

company's assets to liability, other than insurance contracts entered into in the ordinary course of the insurance company's business.

(5) All management ~~and~~ agreements, service contracts, and all cost-sharing arrangements.

(6) Reinsurance agreements.

(7) Dividends and other distributions to shareholders.

(8) Consolidated tax allocation agreements.

d. Any pledge of the insurance company's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

e. Other matters concerning transactions between registered insurance companies 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 the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, or guarantees involving one-half of one percent or less of an insurance company's admitted assets as of December thirty-first next preceding are not material for purposes of this section.

4. ~~Each~~ In addition to the annual filing requirement under subsection 1, each registered insurance company shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms approved by the commissioner within fifteen days after the end of the month in which it learns of each change or addition; provided, however, that subject to ~~subsection 3~~ subsections 7, 8, and 9 of section 26.1-10-05, each registered insurance company shall report all dividends and other distributions to shareholders within ~~ten~~ five business days following the declaration and no less than ten business days prior to payment thereof.

SECTION 14. A new subdivision to subsection 6 of section 26.1-10-05 of the 1991 Supplement to the North Dakota Century Code is created and enacted as follows:

The quality of the company's earnings and the extent to which the reported earnings include extraordinary items.

SECTION 15. AMENDMENT. Subsection 8 of section 26.1-10-05 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

8. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, where the 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 the insurance company's surplus as regards policyholders as of December thirty-first next preceding; or

b. The net gain from operations of the insurance company, if the company is a life insurance company, or the net ~~investment~~ income, if the company is not a life insurance company, not including realized capital gains, for the twelve-month period ending December thirty-first next preceding, but ~~may~~ shall not include pro rata distributions of any class of the insurance company's own securities.

~~In determining whether a dividend or distribution is extraordinary, an insurance company other than a life insurance company may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carryforward must be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.~~

SECTION 16. AMENDMENT. Section 26.1-12-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-08. License required - Prerequisites to issuance of license. A mutual insurance company organized under this chapter may not issue policies or transact any insurance business unless it holds a license from the commissioner authorizing the transaction of insurance business. The license may not be issued unless and until the company complies with the following conditions:

1. It must hold bona fide applications for insurance upon which it will issue simultaneously at least twenty policies to at least twenty members for the same kind of insurance upon not less than two hundred separate risks, each within the maximum single risk.

2. ~~The "maximum single risk" may not exceed twenty percent of the admitted assets of the company, or three times the average risk, or one percent of the insurance in force, whichever is the greater, any reinsurance taking effect simultaneously with the policy being deducted in determining the maximum single risk.~~

~~3.~~ It must have collected a premium upon each application. All premiums must be held in cash or in securities in which insurance companies may invest, and in the case of fire insurance, must be equal to not less than twice the maximum single risk assumed subject to one fire nor less than ten thousand dollars, and in any other kind of insurance as listed in section 26.1-12-11, to not less than five times the maximum single risk assumed nor less than ten thousand dollars.

~~4.~~ 3. It must maintain a surplus of at least one million dollars. However, for any company doing business only in this state, ~~except~~ if the minimum assets and surplus requirements ~~for the company~~ required by this subsection are more than the minimum requirements ~~provided by this subsection~~ at the time the company was ~~originally~~ issued ~~a license~~ its original certificate of authority to do business, the company may maintain assets and surplus which satisfy the requirements in effect at that time. For all other companies, if the minimum assets and surplus requirements required by this subsection are more than the minimum requirements required at the time the company was issued its original certificate of

authority, the company shall increase its surplus of assets over all liabilities according to the following schedule:

a. Two hundred fifty thousand dollars by December 31, 1994.

b. Five hundred thousand dollars by December 31, 1995.

c. Seven hundred fifty thousand dollars by December 31, 1996.

d. One million dollars by December 31, 1997.

SECTION 17. AMENDMENT. Section 26.1-12-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-10. Mutual life company - Amount of subscribed insurance required - Surplus required. A mutual life insurance company may not issue a policy until not less than two hundred thousand dollars of insurance in not less than two hundred separate risks have been subscribed for and entered on its books. The commissioner may not issue a certificate of authority for the transaction of business to the company unless it has a surplus of assets over all liabilities of at least one million dollars. A domestic mutual life insurance company shall maintain surplus of at least this amount. ~~If~~ However, for any company doing business only in this state, if the minimum asset and surplus requirements required by this section are more than the minimum requirements required at the time a company was issued its original certificate of authority, the company shall increase its assets and surplus to a minimum of one hundred thousand dollars. All other companies shall increase their surplus of assets over all liabilities according to the schedule set out in subsection 4 of section 26.1-12-08.

SECTION 18. Chapter 26.1-18.1 of the North Dakota Century Code is created and enacted as follows:

26.1-18.1-01. Definitions.

1. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, and diagnostic and therapeutic radiological services.

2. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

3. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

4. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

5. "Deductible" means the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment.

6. "Enrollee" means an individual who is covered by a health maintenance organization.

7. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder.

8. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

9. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

10. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

11. "Group contractholder" means the person to which a group contract has been issued.

12. "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

13. "Health maintenance organization producer" means an insurance agent or insurance broker, as defined in section 26.1-26-02, who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise holds out to the public as such.

14. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

15. "Insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

16. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

17. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities do not include fully subordinated debt.

18. "Participating provider" means a provider as defined in subsection 20 who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving

payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

19. "Person" means any natural or artificial person including individuals, partnerships, associations, trusts, or corporations.

20. "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

21. "Replacement coverage" means the benefits provided by a succeeding carrier.

22. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

23. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

26.1-18.1-02. Establishment of health maintenance organizations.

1. Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person may establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this chapter. A foreign corporation may qualify under this chapter, subject to its registration to do business in this state as a foreign corporation under section 10-22-01 and compliance with all provisions of this chapter and other applicable state laws.

2. Any health maintenance organization that has not previously received a certificate of authority to operate as a health maintenance organization as of the effective date of this Act shall submit an application for a certificate of authority under subsection 3 within thirty days of the effective date of this Act. Each applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied under section 26.1-18.1-03, the applicant must thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

3. Each application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be in a form prescribed by the commissioner, and must set forth or be accompanied by the following:

   a. A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto.

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

c. A list of the names, addresses, and official positions and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association.

d. A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third-party administrators, marketing consultants, or persons listed in subdivision c and the health maintenance organization.

e. A copy of the form of evidence of coverage to be issued to the enrollees.

f. A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations.

g. Financial statements showing the applicant's assets, liabilities, and sources of financial support. Include both a copy of the applicant's most recent and regular certified financial statement and an unaudited current financial statement.

h. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding.

i. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.

j. A statement or map reasonably describing the geographic area or areas to be served.

k. A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances.

l. A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified.

m. A description of the procedures to be implemented to meet the protection against insolvency requirements in section 26.1-18.1-12.

n. A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements.

o. Such other information as the commissioner may require to make the determinations required in section 26.1-18.1-03.

4. a. The commissioner may adopt rules as the commissioner deems necessary to the proper administration of this chapter to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modifications, or amendments to the items described in subsection 3 to the commissioner, either for the commissioner's approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next succeeding site visit or examination.

b. Any modification or amendment for which the commissioner's approval is required is deemed approved unless disapproved within thirty days, provided that the commissioner may postpone the action for such further time, not exceeding an additional thirty days, as necessary for proper consideration.

26.1-18.1-03. Issuance of certificate of authority.

1. Upon receipt of an application for issuance of a certificate of authority, the commissioner shall issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the commissioner being satisfied that:

a. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.

b. The health maintenance organization's proposed plan of operation meets the requirements of section 26.1-18.1-06.

c. 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 or deductibles.

d. The health maintenance organization is in compliance with sections 26.1-18.1-12 and 26.1-18.1-14.

2. A certificate of authority may be denied only after the commissioner complies with the requirements of section 26.1-18.1-19.

26.1-18.1-04. Powers of health maintenance organizations.

1. The powers of a health maintenance organization include the following:

   a. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization.

   b. Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts between affiliates or between the health maintenance organization and its parent.

   c. The furnishing of health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization.

   d. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration.

   e. The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

   f. The offering of other health care services, in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual.

   g. The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

2. a. A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subdivisions a, b, or d of subsection 1 which may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the exercise of power only if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations.

   b. The commissioner may adopt rules exempting from the filing requirement of subdivision a those activities having a de minimis effect.

26.1-18.1-05. Fiduciary responsibilities.

1. Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization is responsible for the funds in a fiduciary relationship to the organization.

2. If the commissioner deems it necessary for the security of the funds of a health maintenance organization, the commissioner may require an official bond of each officer and each employee of the organization in an amount not to exceed the sum of money for which each is accountable.

26.1-18.1-06. Quality assurance program.

1. The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees will be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures must include mechanisms to assure availability, accessibility, and continuity of care.

2. The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program must include, at a minimum, the following:

   a. A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees.

   b. A written quality assurance plan which describes the following:

      (1) The health maintenance organization's scope and purpose in quality assurance.

      (2) The organizational structure responsible for quality assurance activities.

      (3) Contractual arrangements, where appropriate, for delegation of quality assurance activities.

      (4) Confidentiality policies and procedures.

      (5) A system of ongoing evaluation activities.

      (6) A system of focused evaluation activities.

      (7) A system for credentialing providers and performing peer review activities.

      (8) Duties and responsibilities of the designated physician responsible for the quality assurance activities.

   c. A written statement describing the system of ongoing quality assurance activities including:

      (1) Problem assessment, identification, selection, and study.

      (2) Corrective action, monitoring, evaluation, and reassessment.

      (3) Interpretation and analysis of patterns of care rendered to individual patients by individual providers.

d. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format.

e. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

3. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the commissioner.

4. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

5. Enrollee clinical records must be available to the commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the commissioner. The clinical records are confidential and are not subject to section 44-04-18, except upon written consent for disclosure by the enrollee or the enrollee's authorized representative.

6. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate organization staff.

26.1-18.1-07. Requirements for group contract, individual contract, and evidence of coverage.

1. a. Every group and individual contractholder is entitled to a group or individual contract.

b. The contract may not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by chapter 26.1-04.

c. The contract must contain a clear statement of the following:

(1) Name and address of the health maintenance organization.

(2) Eligibility requirements.

(3) Benefits and services within the service area.

(4) Emergency care benefits and services.

(5) Out-of-area benefits and services, if any.

(6) Copayments, deductibles, or other out-of-pocket expenses.

(7) Limitations and exclusions.

(8) Enrollee termination.

(9) Enrollee reinstatement, if any.

(10) Claims procedures.

(11) Enrollee grievance procedures.

(12) Continuation of coverage.

(13) Conversion.

(14) Extension of benefits, if any.

(15) Coordination of benefits, if applicable.

(16) Subrogation, if any.

(17) Description of the service area.

(18) Entire contract provision.

(19) Term of coverage.

(20) Cancellation of group or individual contractholder.

(21) Renewal.

(22) Reinstatement of group or individual contractholder, if any.

(23) Grace period.

(24) Conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in this subdivision.

2. In addition to those provisions required in subdivision c of subsection 1, an individual contract must provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, the person must pay for the services.

3. a. Every subscriber shall receive an evidence of coverage from the group contractholder or the health maintenance organization.

b. The evidence of coverage may not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by chapter 26.1-04.

c. The evidence of coverage must contain a clear statement of the provisions required in subdivision c of subsection 1.

4. The commissioner may adopt rules establishing readability standards for individual contract, group contract, and evidence of coverage forms.

5. No group or individual contract, evidence of coverage, or amendment thereto, may be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner, as provided by sections 26.1-30-19 and 26.1-30-20.

6. The provisions set forth in sections 26.1-30-20 and 26.1-30-21 govern the approval and disapproval of forms required to be filed under this section.

7. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

26.1-18.1-08. Annual report.

1. Every health maintenance organization shall annually, on or before March first, file a report verified by at least two principal officers with the commissioner, covering the preceding calendar year. The report must be on forms prescribed by the commissioner. In addition, the health maintenance organization shall file by March first, unless otherwise stated:

   a. Audited financial statements on or before June first.

   b. A list of the providers who have executed a contract that complies with subdivision a of subsection 4 of section 26.1-18.1-12.

   c. (1) A description of the grievance procedures.

      (2) The total number of grievances handled through the procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

2. The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter.

26.1-18.1-09. Information to enrollees or subscribers.

1. The health maintenance organization shall provide to its subscribers a list of providers upon enrollment and reenrollment.

2. Every health maintenance organization shall provide within thirty days to its subscribers notice of any material change in the operation of the organization that will affect them directly.

3. An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

4. The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained, and a telephone number where the enrollee can contact the health maintenance organization, at no cost to the enrollee.

26.1-18.1-10. Grievance procedures.

1. Every health maintenance organization shall establish and maintain a grievance procedure which has been approved by the commissioner to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of the grievances.

2. The commissioner may examine the grievance procedures.

26.1-18.1-11. Investments. With the exception of investments made in accordance with subdivision a of subsection 1 of section 26.1-18.1-04, the funds of a health maintenance organization may be invested only in those investments authorized to be made by domestic insurance companies of this state.

26.1-18.1-12. Protection against insolvency.

1. Net worth requirements.

a. Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under subdivision b.

b. Except as provided in subdivisions c and d, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(1) One million dollars;

(2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars;

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

(4) An amount equal to the sum of:

(a) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(b) Four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

c. A health maintenance organization licensed before the effective date of this Act and licensed only in this state must maintain the minimum requirements which are in effect at the time this chapter became law.

d. (1) In determining net worth, no debt may be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

(2) The interest expenses relating to the repayment of any fully subordinated debt must be considered covered expenses.

(3) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, may not be considered a liability and must be recorded as equity.

2. Deposit requirements.

a. Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than three hundred thousand dollars.

b. A health maintenance organization that is licensed only in this state and is in operation on the effective date of this Act shall make a deposit equal to one hundred thousand dollars.

c. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

d. All income from deposits is an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities must be approved by the commissioner before being deposited or substituted.

e. The deposit must be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit is an asset subject to the provisions of the liquidation act.

f. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to the effect, duly authenticated by the appropriate state official holding the deposit.

3. Liabilities. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims. The liabilities must be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

4. Hold harmless.

   a. Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee is not liable to the provider for any sums owed by the health maintenance organization.

   b. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

   c. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

5. Continuation of benefits. The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering a plan, the commissioner may require:

   a. Insurance to cover the expenses to be paid for continued benefits after an insolvency.

   b. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollee's discharge from inpatient facilities.

   c. Insolvency reserves.

   d. Acceptable letters of credit.

   e. Any other arrangements to assure that benefits are continued as specified above.

6. Notice of termination. An agreement to provide health care services between a provider and a health maintenance organization must require that

if the provider terminates the agreement, the provider shall give the organization at least sixty days' advance notice of termination.

26.1-18.1-13. Uncovered expenditures insolvency deposit.

1. If at any time uncovered expenditures exceed ten percent of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit must at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and must be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

2. The deposit required under this section is in addition to the deposit required under section 26.1-18.1-12 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from the deposits or trust accounts is an asset of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

3. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if a substitute deposit of cash or securities of equal amount and value is made, the fair market value exceeds the amount of the required deposit, or the required deposit under subsection 1 is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.

4. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures must be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining must be paid into the liquidation or receivership of the health maintenance organization.

5. The commissioner may by regulation prescribe the time, manner, and form for filing claims under subsection 4.

6. The commissioner may by rule or order require health maintenance organizations to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section.

The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

26.1-18.1-14. Enrollment period and replacement coverage in the event of insolvency.

1. Enrollment period.

a. In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

b. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for the groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

c. The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

2. Replacement coverage.

a. "Discontinuance" means the termination of the contract between the group contractholder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

b. Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

c. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract may be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

26.1-18.1-15. Filing requirements for rating information.

1. No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

2. Either a specific schedule of premium rates, or a methodology for determining premium rates, must be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee may not be individually determined based on the status of the enrollee's health. However, the premium rates may not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

3. The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection 2 are met. The procedures set forth in sections 26.1-30-20 and 26.1-30-21 govern the approval and disapproval of rating information required to be filed under this section.

26.1-18.1-16. Regulation of health maintenance organization producers.

1. The commissioner may adopt rules necessary to provide for the licensing of health maintenance organization producers. The rules must establish:

a. The requirements for licensure of resident health maintenance organization producers.

b. The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers.

c. Any examination, prelicensing, or continuing education requirements.

d. The requirements for registering and terminating the appointment of health maintenance organization producers.

e. Any requirements for registering any assumed names or office locations in which a health maintenance organization producer does business.

f. The conditions for health maintenance organization producer license renewal.

g. The grounds for denial, refusal, suspension, or revocation of a health maintenance organization producer's license.

h. Any required fees for the licensing activities of health maintenance organization producers.

i. Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

2. None of the following may be required to hold a health maintenance organization producer license:

a. Any regular salaried officer or employee of a health maintenance organization who devotes substantially all of the person's time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

b. Employers or their officers or employees or the trustees of any employee benefit plan to the extent that the employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships, provided that the employers, officers, employees, or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing the health maintenance organization memberships;

c. Banks or their officers and employees to the extent that the banks, officers, and employees collect and remit charges by charging same against accounts of depositors on the orders of the depositor; or

d. Any person or the employee of any person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by

the payment of an amount calculated as a percentage of the revenues, net income, or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this chapter.

3. The commissioner may by rule exempt certain classes of persons from the requirement of obtaining a license:

a. If the functions they perform do not require special competence, trustworthiness, or the regulatory surveillance made possible by licensing; or

b. If other existing safeguards make regulation unnecessary.

26.1-18.1-17. Powers of insurers.

1. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law which may be inconsistent, any two or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

2. Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under the laws. Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

26.1-18.1-18. Examinations.

1. The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five years.

2. Every health maintenance organization and provider shall submit its books and records for the examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of the providers concerning their business.

3. The expenses of examinations under this section must be assessed against the health maintenance organization being examined and remitted to the commissioner.

4. In lieu of the examination, the commissioner may accept the report of an examination made by the commissioner of another state.

26.1-18.1-19. Suspension or revocation of certificate of authority.

1. Any certificate of authority issued under this chapter may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner finds that any of these conditions exist:

   a. The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section 26.1-18.1-02, unless amendments to the submissions have been filed with and approved by the commissioner.

   b. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of sections 26.1-18.1-07 and 26.1-18.1-15.

   c. The health maintenance organization does not provide or arrange for basic health care services.

   d. (1) The health maintenance organization does not meet the requirements of section 26.1-18.1-06; or

      (2) The health maintenance organization is unable to fulfill its obligations to furnish health care services.

   e. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

   f. The health maintenance organization has failed to correct, within the time prescribed by subsection 3, any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired.

   g. The health maintenance organization has failed to implement the grievance procedures required by section 26.1-18.1-10 in a reasonable manner to resolve valid complaints.

   h. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

   i. The continued operation of the health maintenance organization would be hazardous to its enrollees.

   j. The health maintenance organization has otherwise failed substantially to comply with this chapter.

2. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to ten thousand dollars for each cause for suspension or revocation.

3. The following pertains when insufficient net worth is maintained:

   a. Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this chapter is less than the minimum net worth required to be maintained by section 26.1-18.1-12, the commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require filing with the commissioner a plan for correction of the deficiency acceptable to the commissioner, and correction of the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the commissioner. Such a deficiency must be deemed an impairment, and failure to correct the impairment in the prescribed time is grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation, or liquidation.

   b. Unless allowed by the commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing the coverage is impaired, and the fact of the impairment is known to the health maintenance organization or to the person. However, the existence of an impairment does not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

4. A certificate of authority must be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

   a. Suspension or revocation of a certificate of authority or the denial of an application or the imposition of an administrative penalty pursuant to this section must be by written order and must be sent to the health maintenance organization or applicant by certified mail. The written order must state the grounds, charges, or conduct on which suspension, revocation, or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty days from the date of mailing of the order. If no written request is made, the order is final upon the expiration of said thirty days.

   b. If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:

(1) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(2) A specific place for the hearing, which may be either in Bismarck, North Dakota, or in the county where the health maintenance organization's or applicant's principal place of business is located.

After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the commissioner shall take whatever action the commissioner deems necessary based on written findings and shall mail the decision to the health maintenance organization or applicant. The action of the commissioner is subject to review under chapter 28-32, or other applicable statutory review process.

5. The provisions of chapter 28-32 apply to proceedings under this section to the extent they are not in conflict with subdivision b of subsection 4.

6. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and may not engage in any advertising or solicitation whatsoever.

7. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It may engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

26.1-18.1-20. Rehabilitation, liquidation, or conservation of health maintenance organizations.

1. Any rehabilitation, liquidation, or conservation of a health maintenance organization must be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in chapter 26.1-06; or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

2. For purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries have the same

priority as established by chapter 26.1-06.1 for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability has the status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan has a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in chapter 26.1-06.1.

26.1-18.1-21. Summary orders and supervision.

1. Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this chapter, the commissioner may, after notice and hearing, order the health maintenance organization to take action as may be reasonably necessary to rectify the condition or violation, including one or more of the following:

   a. Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner.

   b. Reduce the volume of new business being accepted.

   c. Reduce expenses by specified methods.

   d. Suspend or limit the writing of new business for a period of time.

   e. Increase the health maintenance organization's capital and surplus by contribution.

   f. Take other steps as the commissioner may deem appropriate under the circumstances.

2. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject must be deemed a violation of this chapter.

3. The commissioner may set uniform standards and criteria by rule for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards must be consistent with the purposes expressed in subsection 1.

4. The remedies and measures available to the commissioner under this section are in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of section 26.1-06.1-09.

26.1-18.1-22. Rulemaking authority. The commissioner may adopt reasonable rules necessary and proper to carry out the provisions of this chapter.

26.1-18.1-23. Confidentiality of medical information and limitation of liability.

1. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization must be held in confidence and may not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, or upon the express consent of the enrollee or applicant, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against the disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

2. A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee or who furnishes any records, information, or assistance to such a committee is not subject to liability for civil damages or any legal action in consequence of the action, nor is the health maintenance organization which established the committee or the officers, directors, employees, or agents of the health maintenance organization liable for the activities of any person. This section may not be construed to relieve any person of liability arising from treatment of a patient.

3. a. The information considered by a health care review committee and the records of their actions and proceedings is confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director, or other member of a health maintenance organization or its staff engaged in assisting the committee, or any person assisting or furnishing information to the committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on the activities.

   b. Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subdivision a of subsection 3 by a state licensing or certifying agency or in an appeal must be kept confidential and is subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

4. To fulfill its obligations under section 26.1-18.1-06, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any enrollee.

26.1-18.1-24. Acquisition of control of or merger of a health maintenance organization. No person may make a tender for or a request or invitation for

tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization, information required by section 26.1-10-03 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner. Approval by the commissioner must be governed by section 26.1-10-03.

26.1-18.1-25. Coordination of benefits.

1. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

2. If health maintenance organizations adopt coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans.

3. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are received from nonparticipating providers, provided outside their service areas, or not covered under the terms of their group contracts or evidence of coverage.

[1] **SECTION 19. AMENDMENT.** Subsection 3 of section 26.1-26.3-01 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

3. "Managing general agent" means any individual, partnership, or corporation which:

   a. ~~Negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages~~ Manages all or part of the insurance business of an insurer including the management of a separate division, department, or underwriting office, and ~~acts~~

   b. Acts as an agent for the insurer whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any

[1] NOTE: Section 26.1-26.3-01 was also amended by section 106 of Senate Bill No. 2223, chapter 54.

one quarter or year~~, and who either~~ together with one or more of the following activities related to the business produced:

(1) Adjusts or pays claims in excess of an amount determined by the commissioner; or

(2) Negotiates reinsurance on behalf of the insurer.

~~b.~~ c. Notwithstanding the above, the following persons will not be considered as managing general agents for the purposes of this chapter:

(1) An employee of the insurer.

(2) A United States manager of the United States branch of an alien insurer.

(3) An underwriting manager which, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to chapter 26.1-10, and whose compensation is not based on the volume of premiums written.

(4) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

SECTION 20. A new subsection to section 26.1-26.3-06 of the 1991 Supplement to the North Dakota Century Code is created and enacted as follows:

The decision, determination, or order of the commissioner pursuant to subsection 1 of section 26.1-26.3-06 is subject to judicial review pursuant to chapter 28-32.

[2] **SECTION 21. AMENDMENT.** Subsection 6 of section 26.1-26.3-03 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

6. Appropriate underwriting guidelines including:

a. The maximum annual premium volume;

b. The basis of the rates to be ~~charges~~ charged;

c. The types of risks which may be written;

d. Maximum limits of liability;

e. Applicable exclusions;

f. Territorial limitations;

g. Policy cancellation provisions; and

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[2] NOTE: Section 26.1-26.3-03 was also amended by section 106 of Senate Bill No. 2223, chapter 54.

h. The maximum policy period.

The insurer has the right to cancel or nonrenew any policy of insurance subject to the applicable laws and rules concerning the cancellation and nonrenewal of insurance policies.

SECTION 22. AMENDMENT. Section 26.1-26.3-06 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-26.3-06. Penalties and liabilities.

1. If the commissioner ~~finds after a hearing conducted in accordance with chapter 28-32 that any person has violated any provision of~~ determines that the managing general agent or any other person has not materially complied with this chapter or any rule or order adopted under this chapter, after notice and opportunity to be heard, the commissioner may order:

   a. For each separate violation, a penalty in an amount ~~of~~ not exceeding one thousand dollars;

   b. Revocation or suspension of the ~~agent's~~ producer's license; and

   c. ~~The managing general agent to reimburse the insurer, the rehabilitator, or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this chapter committed by the managing general agent.~~ If it was found that because of the material noncompliance that the insurer has suffered any loss or damage, the commissioner may maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors or other appropriate relief.

2. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to chapter 26.1-06.1, and the receiver appointed under that order determines that the managing general agent or any other person has not materially complied with this chapter, or any rule or order adopted under this chapter, and the insurer suffered any loss or damage as a result of the material noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

~~2.~~ 3. Nothing contained in this section affects the right of the commissioner to impose any other penalties provided for in the insurance law.

~~3.~~ 4. Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

SECTION 23. Chapter 26.1-26.5 of the North Dakota Century Code is created and enacted as follows:

26.1-26.5-01. Definitions. As used in this chapter:

1. "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial

regulatory standards promulgated and established from time to time by the national association of insurance commissioners.

2. "Control" or "controlled" has the meaning ascribed in chapter 26.1-10.

3. "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by an insurance broker.

4. "Controlling insurance broker" means an insurance broker who, directly or indirectly, controls an insurer.

5. "Insurance broker" means an insurance broker or brokers or any other person, firm, association, or corporation, when, for any compensation, commission, or other thing of value, such person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association, or corporation.

6. "Licensed insurer" or "insurer" means any person, firm, association, or corporation duly licensed to transact a property and casualty insurance business in this state. The following, inter alia, are not licensed insurers for the purposes of this chapter:

   a. All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986 [Pub. L. No. 99-499, 100 Stat. 1613] and the Risk Retention Act [15 U.S.C. section 39-01 et seq.] and chapter 26.1-46.

   b. All residual market pools and joint underwriting authorities or associations.

   c. All captive insurers. For the purposes of this chapter, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates.

26.1-26.5-02. Applicability. This chapter applies to licensed insurers as defined in section 26.1-26.5-01, either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of the Insurance Holding Company Act, to the extent they are not superseded by this chapter, continue to apply to all parties within holding company systems subject to this chapter.

26.1-26.5-03. Minimum standards.

1. a. The provisions of this section apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling insurance broker is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September thirtieth of the prior year.

b. Notwithstanding subdivision a, the provisions of this section do not apply if:

(1) The controlling insurance broker places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and accepts insurance placements only from nonaffiliated insurance brokers, and not directly from insureds.

(2) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling insurance broker, an insurance broker controlled by the controlled insurer, or an insurance broker that is a subsidiary of the controlled insurer.

2. A controlled insurer may not accept business from a controlling insurance broker and a controlling insurance broker may not place business with a controlled insurer unless there is a written contract between the controlling insurance broker and the insurer specifying the responsibilites of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

a. The controlled insurer may terminate the contract for cause, upon written notice to the controlling insurance broker. The controlled insurer shall suspend the authority of the controlling insurance broker to write business during the pendency of any dispute regarding the cause for the termination.

b. The controlling insurance broker shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the controlling insurance broker.

c. The controlling insurance broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date must be fixed so that premiums or installments thereof collected shall be remitted no later than ninety days after the effective date of any policy placed with the controlled insurer under this contract.

d. All funds collected for the controlled insurer's account must be held by the controlling insurance broker in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling insurance broker not required to be licensed in this state must be maintained in compliance with the requirements of the controlling insurance broker's domiciliary jurisdiction.

e. The controlling insurance broker shall maintain separately identifiable records of business written for the controlled insurer.

f. The contract may not be assigned, in whole or in part, by the controlling insurance broker.

g. The controlled insurer shall provide the controlling insurance broker with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling insurance broker shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions must be the same as those applicable to comparable business placed with the controlled insurer by an insurance broker other than the controlling insurance broker.

h. The rates and terms of the controlling insurance broker's commissions, charges, or other fees and the purposes for those charges or fees. The rates of the commissions, charges, and other fees must be no greater than those applicable to comparable business placed with the controlled insurer by insurance brokers other than controlling insurance brokers. For purposes of this subdivision and subdivision g, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

i. If the contract provides that the controlling insurance broker, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation may not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event may the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subdivision a of subsection 4.

j. A limit on the controlling insurance broker's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling insurance broker when the applicable limit is approached and may not accept business from the controlling insurance broker if the limit is reached. The controlling insurance broker may not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

k. The controlling insurance broker may negotiate but may not bind reinsurance on behalf of the controlled insurer on business the controlling insurance broker places with the controlled insurer, except that the controlling insurance broker may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

3. Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

4. a. In addition to any other required loss reserve certification, the controlled insurer shall annually, on April first of each year, file with the commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of yearend, including incurred but not reported, on business placed by the insurance broker.

b. The controlled insurer shall annually report to the commissioner the amount of commissions paid to the insurance broker, the percentage such amount represents of the net premiums written, and comparable amounts and percentage paid to noncontrolling insurance brokers for placements of the same kinds of insurance.

26.1-26.5-04. Disclosure. The insurance broker, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the insurance broker and the controlled insurer, except that, if the business is placed through an insurance broker who is not a controlling insurance broker, the controlling insurance broker shall retain in his records a signed commitment from the insurance broker that the insurance broker is aware of the relationship between the insurer and the insurance broker and that the insurance broker has or will notify the insured.

26.1-26.5-05. Liability of controlling insurance broker in the event of insolvency of controlled insurer. If the commissioner has reason to believe that a controlling insurance broker has commited or is committing an act which could be determined to be a violation, and that the violation substantially contributed to the insolvency of a controlled insurer, the commissioner or receiver may maintain a civil action against the controlling insurance broker for all damages caused by the insurance broker's acts.

26.1-26.5-06. Administrative penalties and actions by the commissioner.

1. In addition to any other remedies provided herein, whenever it appears to the commissioner that a person has committed or is committing an act that could be determined to be a violation, the commissioner may institute a proceeding under chapter 28-32. After the hearing, the commissioner may order any or all of the following:

a. That the person permanently cease and desist from committing the acts found to be in violation of this chapter.

b. Payment of a penalty of not more than ten thousand dollars for each and every act or violation.

c. That the controlling insurance broker cease placing business with the controlled insurer.

2. If it is found, after hearing, that the controlling broker or any other person has not materially complied with this chapter and that the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

3. If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to chapter 26.1-06.1, and the receiver appointed under that order believes that the controlling insurance broker or any other person has not materially complied with this chapter, or any rule or order adopted hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

4. Nothing contained in this section affects the right of the commissioner to impose any other penalties provided for in the insurance law.

5. Nothing contained in this section is intended to or in any manner alters or affects the rights of policyholders, claimants, creditors, or other third parties.

26.1-26.5-07. Effective date. Within sixty days of the effective date of this Act, each controlled insurer and each controlling insurance broker must comply with the provisions of sections 26.1-26.5-03 and 26.1-26.5-04.

[3] **SECTION 24. AMENDMENT.** Subdivision c of subsection 8 of section 26.1-31.1-01 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

c. An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer and ~~be~~ subject to chapter 26.1-10, and whose compensation is not based on the volume of premiums written.

SECTION 25. A new subsection to section 26.1-31.1-02 of the 1991 Supplement to the North Dakota Century Code is created and enacted as follows:

Licensed attorneys at law of this state when acting in their professional capacity as such are exempt from this section.

SECTION 26. AMENDMENT. Subsection 1 of section 26.1-31.1-06 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

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[3] NOTE: Section 26.1-31.1-01 was also amended by section 106 of Senate Bill No. 2223, chapter 54.

SECTION 27. AMENDMENT. Subsection 6 of section 26.1-31.1-07 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

6. Jointly employ an individual who is employed by the reinsurer unless such reinsurance intermediary-manager is under common control with the reinsurer subject to chapter 26.1-10.

SECTION 28. AMENDMENT. Section 26.1-31.1-10 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-31.1-10. Penalties and liabilities.

1. ~~A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing, to be in violation of any provision of this chapter, shall~~ If the commissioner determines that the reinsurance intermediary or any other person has not materially complied with this chapter, or any rule or order adopted under this chapter, after notice and opportunity to be heard, the commissioner may order:

   a. For each separate violation, ~~pay~~ a penalty in an amount not exceeding five thousand dollars;

   b. ~~Be subject to revocation~~ Revocation or suspension of ~~its~~ the reinsurance intermediary's license; and

   c. If ~~a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation~~ it was found that because of the material noncompliance the insurer or reinsurer has suffered any loss or damage, the commissioner may maintain a civil action brought by or on behalf of the reinsurer or insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the reinsurer or insurer and its policyholders and creditors or seek other appropriate relief.

2. If an order of rehabilitation or liquidation of the insurer has been entered pursuant to chapter 26.1-06.1, and the receiver appointed under that order determines that the reinsurance intermediary or any other person has not materially complied with this chapter, or any rule or order adopted under this chapter, and the insurer suffered any loss or damage as a result of the material noncompliance, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

3. Nothing contained in this section affects the right of the commissioner to impose any other penalties provided for in the insurance law.

~~3.~~ 4. Nothing contained in this chapter is intended to or may in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties ~~or confer any rights to such persons~~.

5. The decision, determination, or order of the commissioner pursuant to subsection 1 of this section is subject to judicial review pursuant to chapter 28-32.

SECTION 29. AMENDMENT. Subdivision d of subsection 2 of section 26.1-31.2-01 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

d. Files ~~each year by March first~~ annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and either

(1) Maintains a surplus as regards policyholders in an amount which is not less than twenty million dollars and whose accreditation has not been denied by the commissioner within ninety days of its submission; or

(2) Maintains a surplus as regards policyholders in an amount less than twenty million dollars and whose accreditation has been approved by the commissioner.

No credit may be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing.

SECTION 30. AMENDMENT. Subdivisions b and d of subsection 4 of section 26.1-31.2-01 of the 1991 Supplement to the North Dakota Century Code are amended and reenacted as follows:

b. In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in subdivision a, and which ~~is under the supervision of the department of trade and industry of the United Kingdom~~ has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation and submits to this state's authority to examine its books and records and bears the expense of the examination, and which has aggregate policyholders' surplus of ten billion dollars; the trust must be in an amount equal to the group's several liabilities attributable to business ~~written in the United States~~ ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group plus the group shall maintain a joint trusteed surplus of which one hundred million dollars must be held jointly and exclusively for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities, and each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

d. No later than ~~March first~~ February twenty-eighth of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding yearend and shall certify the date of

termination of the trust, if so planned, or certify that the trust will not expire prior to the next following December thirty-first.

SECTION 31. AMENDMENT. Subsection 2 of section 26.1-31.2-02 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

2. Securities listed by the securities valuation office of the national association of insurance commissioners and qualifying as admitted assets ~~under this state's investment statutes~~.

SECTION 32. Section 26.1-35-01.1 of the North Dakota Century Code is created and enacted as follows:

26.1-35-01.1. Actuarial opinion of reserves. This section becomes operative at the end of the first full calendar year following the year of enactment.

1. Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

2. Actuarial analysis of reserves and assets supporting such reserves.

   a. Every life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by subsection 1, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts.

   b. The commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinon required by this section.

3. Requirement for opinion under subsection 2. Each opinion required by subsection 2, must be governed by the following provisions:

   a. A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

   b. If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by rule or is otherwise unacceptable to the commissioner, the commissioner may

engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

4. Requirement for all opinions. Every opinion must be governed by the following provisions:

a. The opinion must be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994.

b. The opinion must apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

c. The opinion must be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the commissioner may by rule prescribe.

d. In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

e. For the purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in such regulations.

f. Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

g. Disciplinary action by the commissioner against the company or the qualified actuary must be defined in rules by the commissioner.

h. Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, must be kept confidential by the commissioner and may not be made public and is not subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules adopted hereunder; provided, however, that the memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum are no longer confidential.

SECTION 33. AMENDMENT. Section 26.1-35-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-35-07. Minimum aggregate reserves for life policies issued after June 30, 1977.

1. A company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued after June 30, 1977, may not be less than the aggregate reserves calculated in accordance with the methods set forth in sections 26.1-35-05, 26.1-35-06, and 26.1-35-09 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

2. In no event may the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by section 26.1-35-01.1.

SECTION 34. AMENDMENT. Section 26.1-35-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-35-08. Calculation of minimum aggregate reserves by other standards. Reserves for all policies and contracts issued prior to July 1, 1977, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for the policies and contracts than the minimum reserves required by the laws in effect on June 30, 1977.

Reserves for any category of policies, contracts, or benefits, as established by the commissioner, issued on or after July 1, 1977, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this chapter, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies and contracts. Any company that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this chapter may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum provided in this chapter; provided, however, that for the purposes of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by section 26.1-35-01.1 may not be deemed to be the adoption of a higher standard of valuation.

SECTION 35. A new subsection to section 26.1-46-01 of the North Dakota Century Code is created and enacted as follows:

"Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by any person who performs that work or any person who hires an independent contractor to perform that work, but includes liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

SECTION 36. Two new subdivisions to subsection 7 of section 26.1-46-01 of the North Dakota Century Code are created and enacted as follows:

Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations.

Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state.

SECTION 37. AMENDMENT. Subdivisions a and e of subsection 7 of section 26.1-46-01 of the North Dakota Century Code are amended and reenacted as follows:

a. ~~The~~ For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.

e. Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, reinsurance agreements, and investment policies.

SECTION 38. AMENDMENT. Subsection 10 of section 26.1-46-01 of the North Dakota Century Code is amended and reenacted as follows:

10. "Risk retention group" means any corporation or other limited liability association ~~formed under the laws of any state, Bermuda, or the Cayman Islands and which meets the qualifications for such groups as defined in the federal Product Liability Risk Retention Act of 1981 as amended.~~:

a. Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members.

b. Which is organized for the primary purpose of conducting the activity described under subdivision a.

c. Which is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or, before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986.

d. Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person.

e. Which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group,

or has its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group.

f. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations.

g. Whose activities do not include the provision of insurance other than:

(1) Liability insurance for assuming and spreading all or any portion of the liability of its group members.

(2) Reinsurance with respect to the liability of any other risk retention group or any members of such other group which is engaged in business or activities so that the group or member meets the requirement described in subdivision f from membership in the risk retention group which provides such reinsurance.

h. The name of which includes the phrase "risk retention group".

SECTION 39. AMENDMENT. Section 26.1-46-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-46-02. Risk retention groups chartered in this state. A risk retention group seeking to be chartered in this state must be chartered and licensed as a liability insurance company authorized by the insurance laws of this state and, except as provided elsewhere in this chapter, shall comply with all of the laws, rules, regulations, and requirements applicable to such insurers chartered and licensed in this state and with section 26.1-46-03 to the extent such requirements are not a limitation on laws, rules, regulations, or requirements of this state. Notwithstanding any other provision to the contrary, all risk retention groups chartered in this state shall file with the department and the national association of insurance commissioners, an annual statement in a form prescribed by the national association of insurance commissioners and in diskette form, if required by the commissioner, and completed in accordance with its instructions and the national association of insurance commissioners accounting practices and procedures manual. Before it may offer insurance in any state, each risk retention group doing business in this state ~~which has more than twenty-five~~, except for a risk retention group chartered in this state which does business only in this state and which has fewer than twenty-six resident members or insureds, shall also submit for approval to the insurance commissioner of this state a plan of operation or a feasibility study and revisions of such plan or study if the group intends to offer any additional lines of liability insurance. Immediately upon receipt of an application for charter in this state the risk retention group shall provide summary information concerning the filing to the national association of insurance commissioners including the name of the risk retention group, the identity of the initial members of the group, the identity of the individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the commissioner shall forward the information to the national

association of insurance commissioners. Providing notification to the national association of insurance commissioners is in addition to, and is not sufficient to satisfy, the requirements of this chapter.

SECTION 40. AMENDMENT. Subsection 1 of section 26.1-46-03 of the North Dakota Century Code is amended and reenacted as follows:

1. Notice of operations and designation of commissioner as agent. Before offering insurance in this state, a risk retention group shall submit to the commissioner on a form prescribed by the national association of insurance commissioners all of the following:

   a. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and such other information, including information on its membership, as the commissioner of this state may require to verify that the risk retention group is qualified under subsection 10 of section 26.1-46-01.

   b. ~~For risk retention groups doing business in this state which have more than twenty-five resident members or insureds, a~~ A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to its state of domicile; provided, however, that the provision relating to the submission of a plan of operation or a feasibility study does not apply with respect to any line or classification of liability insurance which was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986, and was offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date.

   c. The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by section 26.1-46-02 at the same time that the revision is submitted to the commissioner of its chartering state.

   d. A statement of registration, for which a filing fee must be determined by the commissioner, which designated the commissioner as its agent for the purpose of receiving service of legal documents or process.

SECTION 41. A new subdivision to subsection 3 of section 26.1-46-03 of the North Dakota Century Code is created and enacted as follows:

To the extent that insurance agents or brokers are utilized pursuant to section 26.1-46-11, each agent or broker shall keep a complete and separate record of all policies procured from each risk retention group, which record must be open to examination by the commissioner, as provided in sections 26.1-03-19.1 through 26.1-03-22. These records must, for each policy and each kind of insurance provided thereunder, include the limit of liability, the time period covered, the effective date, the name of the risk retention group which issued the policy, the gross premium charged, and the amount of return premiums, if any.

SECTION 42. Two new subsections to section 26.1-46-03 of the North Dakota Century Code are created and enacted as follows:

Any risk retention group, its agents, and representatives shall comply with chapter 26.1-04. The terms of any insurance policy issued by any risk retention group may not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

A risk retention group that violates any provisions of this chapter will be subject to fines and penalties including revocation of its right to do business in this state, applicable to licensed insurers generally. In addition to complying with the requirements of this section, any risk retention group operating in this state prior to enactment of this chapter shall, within thirty days after the effective date of this chapter, comply with the provision of subdivision a of subsection 1.

SECTION 43. AMENDMENT. Section 26.1-46-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-46-04. Compulsory associations.

1. No risk retention group may join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor may any risk retention group, or its insureds, receive any benefit from any such fund for claims arising out of the operations of such risk retention group.

2. When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resided or located, may be covered by any insurance guaranty fund or similar mechanism in this state.

3. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state may be covered by the state guaranty fund subject to chapter 26.1-42.

SECTION 44. AMENDMENT. Section 26.1-46-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-46-06. Purchasing groups - Exemption from certain laws relating to the group purchase of insurance. ~~Any purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 is exempt from any law of this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members. In addition, an insurer is exempt from any law of this state which prohibits providing, or offering to provide, to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group is subject to all other applicable laws of this state.~~ A purchasing group and its insurer or insurers is subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers are exempt, in regard to liability insurance for the purchasing group, from any law that would:

1. Prohibit the establishment of a purchasing group.

2. Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters.

3. Prohibit a purchasing group or its members from purchasing insurance on a group basis described in subsection 2.

4. Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time.

5. Require that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form.

6. Require that a certain percentage of a purchasing group must obtain insurance on a group basis.

7. Otherwise discriminate against a purchasing group or any of its members.

8. Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

SECTION 45. AMENDMENT. Section 26.1-46-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-46-07. Notice and registration requirements of purchasing groups.

1. A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the commissioner on forms prescribed by the national association of insurance commissioners which must do all of the following:

   a. Identify the state in which the group is domiciled.

   b. Identify all other states in which the group intends to do business.

   c. Specify the lines and classifications of liability insurance which the purchasing group intends to purchase.

   ~~c.~~ d. Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company.

   e. Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state.

   ~~d.~~ f. Identify the principal place of business of the group.

   ~~e.~~ g. Provide such other information as may be required by the commissioner to verify that the purchasing group is qualified under subsection 9 of section 26.1-46-01.

2. A purchasing group shall, within ten days, notify the commissioner of any changes in any of the items set forth in subsection 1.

3. The purchasing group shall register with and designate the commissioner of insurance as its agent solely for the purpose of receiving service of legal documents or process, except that such requirements do not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Products Liability Risk Retention Act of 1981 to which all of the following apply:

   a. The group was domiciled before April 1, 1986, and is domiciled on and after October 27, 1986, in any state of the United States.

   b. Before October 27, 1986, the group purchased insurance from an insurance carrier licensed in any state and since October 27, 1986, the group purchased its insurance from an insurance carrier licensed in any state.

   c. The group was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 before October 27, 1986.

   d. The group does not purchase insurance that was not authorized for purposes of an exemption under that Act, as in effect before October 27, 1986.

   e. Each purchasing group that is required to give notice pursuant to subsection 1 shall also furnish such information as may be required by the commissioner to verify that the entity qualifies as a purchasing group, determine where the purchasing group is located, and determine appropriate tax treatment.

   f. Any purchasing group which was doing business in this state prior to the enactment of this chapter shall, within thirty days after the effective date of this Act, furnish notice to the commissioner pursuant to the provisions of subsection 1 and furnish such information as may be required pursuant to subsections 2 and 3.

SECTION 46. AMENDMENT. Section 26.1-46-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-46-08. Restrictions on insurance purchased by purchasing groups.

1. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

2. A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of the group which have a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state, and that the risk retention group or insurer may not be subject to all insurance laws and rules of this state.

3. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

4. Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

SECTION 47. Section 26.1-46-08.1 of the North Dakota Century Code is created and enacted as follows:

26.1-46-08.1. Purchasing group taxation. Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing must be:

1. Imposed at the same rate and subject to the same interest, fines, and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

2. Paid first by such insurance source, and if not by such source, by the agent or broker for the purchasing group, and if not by such agent or broker, then by the purchasing group, and if not by such purchasing group, then by each of its members.

SECTION 48. AMENDMENT. Section 26.1-46-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-46-09. Administrative and procedural authority regarding risk retention groups and purchasing groups. The commissioner is authorized to make use of any of the powers and requirements established under title 26.1 so long as those powers or requirements are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986. This includes, but is not limited to, the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, ~~and~~ impose penalties, and seek injunctive relief. With regard to any investigation, administrative proceedings, or litigation, the commissioner can rely on the procedural law and regulations of the state. The injunctive authority of the commissioner in regard to risk retention groups is restricted by the requirements that any injunction be issued by a court of competent jurisdiction.

[4] **SECTION 49. REPEAL.** Sections 26.1-03-02, 26.1-03-19, 26.1-03-20, 26.1-03-21, 26.1-12-17, chapters 26.1-18, and 26.1-26.2 of the North Dakota Century Code are repealed.

Approved April 12, 1993
Filed April 12, 1993

[4] NOTE: Section 26.1-18-29 was also amended by section 12 of House Bill No. 1045, chapter 45.

CHAPTER 293

HOUSE BILL NO. 1166
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE REVISIONS

AN ACT to amend and reenact section 26.1-03-07, subsection 9 of section 26.1-10-05, section 26.1-22-05, subsection 1 of section 26.1-25-02, sections 26.1-26-31.3, 26.1-26-44, subdivision j of subsection 1 of section 26.1-36-04, and subsection 2 of section 26.1-36-09.1 of the North Dakota Century Code, relating to annual statement filing date, insurance holding company systems, fire and tornado fund, accreditation of courses, notification of license status, insurance rates, claim payments, and mammogram examination coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-07. Annual statement to be filed. Every insurance company doing business in this state shall transmit to the commissioner, not later than March first of each year, a statement of its condition and business for the year ending on the preceding December thirty-first. If March first falls on a Saturday or legal holiday, the statement is due on the next succeeding business day. A company organized under the law of any foreign country or province shall include in the statement only business transacted within the United States, and shall file a supplemental statement of business transacted without the United States not later than December first. The commissioner shall stamp the date of receipt on every statement. The commissioner may not accept the annual statement from any company if the statement was transmitted after the date designated in this section unless the statement is accompanied by the penalty prescribed by section 26.1-03-16.

SECTION 2. AMENDMENT. Subsection 9 of section 26.1-10-05 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

9. Notwithstanding any other provision of law, an insurance company may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and the declaration confers no rights upon shareholders until:

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

   b. The commissioner has not disapproved the payment within the thirty-day period referred to in subsection ~~3~~ 7.

SECTION 3. AMENDMENT. Section 26.1-22-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-05. Public, international peace garden, and winter show buildings insurable in fund. The public buildings and fixtures and permanent contents therein belonging to the state, the various state industries, and the political subdivisions must, and the buildings and fixtures and the permanent contents therein belonging to an international peace garden or a winter show~~,~~ may, be insured under this chapter. No officer or agent of the state or of any political subdivision, and no person having charge of any public buildings belonging to the state, any state industry, or any political subdivision, may pay out any public moneys or funds on account of any insurance against loss by fire, lightning, inherent explosion, windstorm, cyclone, tornado and hail, explosion, riot attending a strike, aircraft, smoke, vehicles, or any other risks of direct physical loss, or contract in any manner for, or incur any indebtedness against, the state or any political subdivision on account of any such insurance upon any of the buildings or fixtures and permanent contents therein belonging to the state or any political subdivision, except in the manner provided in this chapter.

[1] **SECTION 4. AMENDMENT.** Subsection 1 of section 26.1-25-02 of the North Dakota Century Code is amended and reenacted as follows:

1. Reinsurance other than joint reinsurance to the extent stated in section ~~26.1-25-11~~ 26.1-25-10.5.

SECTION 5. AMENDMENT. Section 26.1-26-31.3 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-31.3. Accreditation of courses. The commissioner shall adopt by rule criteria for the accreditation of courses for continuing or prelicensure education. Applications for accreditation of any course offered in this state for continuing or prelicensure education must be submitted to the commissioner within the time prescribed by rule and on forms prescribed by rule and with a fee of fifty dollars. ~~Application must be made at least three months prior to the proposed date of the course.~~ The advisory task force shall recommend to the commissioner whether any course satisfies the criteria for accreditation and the number of credit hours to be assigned to the course. The commissioner shall make a final determination as to accreditation and assignment of credit hours for courses.

SECTION 6. AMENDMENT. Section 26.1-26-44 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-44. Notification of suspension, revocation, or refusal - Duty of commissioner. The commissioner shall promptly notify all appointing insurers, where applicable, and the licensee regarding any suspension, revocation, or refusal of a license by the commissioner.

Upon suspension, revocation, or refusal of the license of a resident of this state, the commissioner shall notify the central office of the national association of insurance commissioners ~~and the insurance commissioner of each state for whom the commissioner has executed a certificate as provided for in accordance with subsection 2 of section 26.1-26-25~~.

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[1] NOTE: Section 26.1-25-02 was also amended by section 13 of House Bill No. 1045, chapter 45.

SECTION 7. AMENDMENT. Subdivision j of subsection 1 of section 26.1-36-04 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

j. A provision that all benefits payable under the policy other than benefits for loss of time will be payable ~~not more than sixty days after receipt of proof~~ according to the provisions of section 26.1-36-37.1, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of proof of loss.

SECTION 8. AMENDMENT. Subsection 2 of section 26.1-36-09.1 of the North Dakota Century Code is amended and reenacted as follows:

2. This section does not apply to individually guaranteed renewable supplemental, specified disease, long-term care, or other limited benefit policies.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 294

SENATE BILL NO. 2340
(Senator Schoenwald)

PRODUCT LIABILITY INFORMATION

AN ACT to amend and reenact section 26.1-03-13 of the North Dakota Century Code, relating to reporting of product liability information.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-13. Reporting of product liability information. Every insurance company providing product liability insurance or excess insurance above self-insurance to any manufacturer, seller, or distributor in this state shall file with the commissioner annually, not later than April first, a report ~~containing the following information~~ for the one-year period ending December thirty-first of the previous year~~:~~

~~1. The name of the insurance company.~~

~~2. The name of all other insurance companies associated with the company submitting the report.~~

~~3. The states in which the company has been admitted for product liability insurance.~~

~~4. The dollar amount collected in product liability earned premiums and the dollar amount of product liability incurred losses in this state and on a nationwide basis.~~

~~5. The amounts shown in answer to subsection 4 which include any other insurance delivered as part of a package which cannot be considered exclusively product liability insurance.~~

~~6. The total number of insureds, resident or located in North Dakota, for which the insurance company provided product liability insurance.~~

~~7. The total number of insureds, resident or located in North Dakota, whose product liability insurance coverage the company canceled or refused to renew and the reasons therefor.~~

~~8. The percentage of product liability premiums that are incurred for the following:~~

~~a. Losses, including all loss adjustment expenses ratioed to premiums earned.~~

~~b. Commissions, ratioed to premiums written.~~

~~c. Taxes, ratioed to premiums written.~~

~~d. All other expenses, ratioed to premiums earned.~~

~~e. The total of all expenses included in subdivisions a through d, ratioed to premiums earned.~~

~~f. Profits and reserves, ratioed to premiums earned.~~

~~9. The basis upon which the company allocates premiums received and losses incurred from a multistate product liability risk, whether it be assigned to the risk's state or domicile, allocated to each state in which the risk has a physical plant, allocated to each state on the basis of sales in each state, or allocated on some other basis~~.

The report must be in the format established by the commissioner ~~and a copy of the insurance company's most recent annual report to shareholders or policyholders must be submitted with the report~~. If any of the required data is estimated, that fact must be clearly indicated.

Approved March 24, 1993
Filed March 25, 1993

CHAPTER 295

SENATE BILL NO. 2494
(Senators Nething, Mutch)
(Representatives Dorso, Wald)

INSURANCE COMPANY REDOMESTICATION

AN ACT to create and enact three new sections to chapter 26.1-05 of the North Dakota Century Code, relating to redomestication of insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Three new sections to chapter 26.1-05 of the North Dakota Century Code are created and enacted as follows:

Approval of the domestic insurer - Premium waiver.

1. An insurer organized under the laws of another state which is admitted to do business in this state for the purpose of writing insurance may be a domestic insurer by complying with the requirements of law relative to the organization and licensing of a domestic insurer of the same type in this state and by designating its principal place of business at a place in this state. For purposes of this section, a company is deemed to have designated its principal place of business at a place in this state if the company locates its home office in this state. If an insurer seeks to become a domestic insurer but is unable to designate its principal place of business in this state, the insurer may place on deposit with the Bank of North Dakota, upon the approval of the commissioner, a sum established by the commissioner, which may not be withdrawn without the approval of the commissioner. An insurer that complies with this subsection is entitled to the certificates and licenses to transact the business of a domestic insurer in this state and is subject to the authority and jurisdiction of this state.

2. After an insurance company has redomesticated to this state and located and maintained its home office in this state, the insurance company is allowed a credit against the premium tax imposed and due under section 26.1-03-17 for an amount equal to the premium tax paid in this state during the first two years as a domestic company in this state. This credit must be used in the third and fourth years following the company's redomestication to this state and may not be carried over beyond the fourth year.

Conversion to foreign insurer. A domestic insurer, upon the approval of the commissioner, may transfer its domicile to another state in which it is admitted to transact the business of insurance. Upon transfer, the insurer ceases to be a domestic insurer and, if qualified, may be admitted to this state as a foreign insurer. The commissioner shall approve a proposed transfer unless the commissioner determines the transfer is not in the interests of the policyholders of the state.

Effects of redomestication. In the discretion of the commissioner, the certificate of authority, agent appointments and licenses, rates, and other items in existence at the time an insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this state or another state by merger, consolidation, or any other lawful method, continue in effect upon the transfer if the insurer remains duly qualified to transact the business of insurance in this state. An outstanding policy of a transferring insurer remains in effect and does not need to be endorsed as to the new name of the company or its new location unless so ordered by the commissioner. A transferring insurer shall file new policy forms with the commissioner on or before the effective date of the transfer, but may use existing forms with appropriate endorsements as approved by the commissioner. A transferring insurer shall notify the commissioner of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the commissioner.

Approved March 26, 1993
Filed March 26, 1993

CHAPTER 296

SENATE BILL NO. 2527
(Senators Mathern, Graba)
(Representative D. Olsen)

HEALTH COVERAGE MINIMUM BENEFITS

AN ACT to amend and reenact subdivision a of subsection 1 of section 26.1-08-05, subsection 2 of section 26.1-08-05, subdivision a of subsection 1 of section 26.1-08-06, subsection 2 of section 26.1-08-06, and subsection 4 of section 26.1-08-12 of the North Dakota Century Code, relating to minimum benefits of a qualified health coverage plan.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subdivision a of subsection 1 of section 26.1-08-05 of the North Dakota Century Code is amended and reenacted as follows:

a. The minimum benefits for covered individuals must, subject to this subdivision, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which must not be less than five hundred dollars per person. The coverage must 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~~ five hundred ~~fifty~~ thousand dollars.

SECTION 2. AMENDMENT. Subsection 2 of section 26.1-08-05 of the North Dakota Century Code is amended and reenacted as follows:

2. A plan of health coverage is 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 must not be less than one thousand dollars per person. The coverage must 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~~ five hundred ~~fifty~~ thousand dollars.

SECTION 3. AMENDMENT. Subdivision a of subsection 1 of section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

a. The minimum benefits for covered individuals must, subject to this subdivision, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which must not be less than five hundred dollars per person. The coverage must 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~~ five hundred ~~fifty~~ thousand dollars.

SECTION 4. AMENDMENT. Subsection 2 of section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

2. A plan of health coverage is 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 must not be less than one thousand dollars per person. The coverage must 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~~ five hundred ~~fifty~~ thousand dollars.

SECTION 5. AMENDMENT. Subsection 4 of section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

4. A person who obtains coverage pursuant to this section may not be covered for maternity during the first two hundred seventy days or any other preexisting condition during the first ~~six months~~ one hundred eighty days of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the date of the application. Any person with coverage through the association plan due to a catastrophic condition or major illness who is also pregnant at the time of application is eligible for maternity benfits after the first one hundred eighty days of coverage. This subsection does not apply to a person receiving nonelective procedures who has lost dependent status under a parent's or guardian's ~~family or group~~ policy ~~and who has had continuous coverage under a family or group policy~~ that has been in effect for the twelve-month period immediately preceding the filing of an application ~~for nonelective procedures~~ or to a person who is treated by nonelective procedures for a congenital or genetic disease.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 297

HOUSE BILL NO. 1170
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

NONPROFIT HEALTH SERVICE DIRECTORS

AN ACT to amend and reenact section 26.1-17-04 of the North Dakota Century Code, relating to the powers and election of the board of directors for nonprofit health service corporations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-04 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-17-04. Directors - Responsibilities. A board of directors shall manage the business and affairs of a health service corporation and has the power to amend bylaws. The board is to consist of at least nine members. At least a majority of the directors of a health service corporation writing hospital or medical service contracts under this chapter must be at all times subscribers.

A subscriber director is a director who is a subscriber and who is not a provider of health care, a person who has a material financial or fiduciary interest in the delivery of health care services or a related industry, an employee of an institution that provides health care services, or a spouse or a member of the immediate family of such a person. Nominations for and election of the ~~replacement of~~ subscriber directors must be made by the existing ~~subscriber~~ directors.

A director may serve on the board of only one corporation subject to this chapter at a time.

Population factors, representation of different geographic regions, and the demography of the service area of the corporation subject to this chapter must be considered when making nominations for the board of directors of a corporation subject to this chapter.

A health service corporation may not reimburse or compensate a director for more than necessary and actual expenses for service as a member of the board of directors.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 298

HOUSE BILL NO. 1456
(Representatives Dorso, Howard)
(Senator DeMers)

NONPROFIT HEALTH SERVICE CONTRACTS

AN ACT to amend and reenact section 26.1-17-12 of the North Dakota Century Code, relating to contract limitations for nonprofit health service corporations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-12 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-17-12. Contract limitations.

1. Except as provided in this section, every physician, oral surgeon, dentist, or practitioner licensed and registered in ~~the~~ this state ~~of North Dakota~~ has the right to contract with any health service corporation for furnishing general or special medical care, dental care, or optometric care, as the case may be~~, but the governing board of a corporation may refuse to contract or may terminate a contract if the board determines that a physician, oral surgeon, dentist, or practitioner is providing inappropriate or substandard care to the corporation's subscribers~~. A corporation may not impose any restriction as to the methods of diagnosis or treatment. The private relationship of physician and patient, dentist and patient, or practitioner and patient is to be maintained at all times and the subscriber has the right of free choice in selecting any physician, oral surgeon, dentist, or practitioner.

2. The governing board of a health service corporation that writes hospital or medical service contracts may terminate a practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose reasonable sanctions on any practitioner who continues to engage in a practice pattern that is excessive or inappropriate as compared to the practice pattern for the practitioner's specialty after having been informed by the corporation, in writing, as to the manner in which the practitioner's practice pattern is excessive or inappropriate. The corporation shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the practitioner's practice pattern. If, after terminating a practitioner's participating contract with the corporation, the practitioner's practice pattern continues to be excessive or inappropriate, the corporation's central professional services committee may consider recommending to the board that the practitioner be designated nonpayable. The affected practitioner must be given the right to be present and to be heard by the committee which must include representation of the practitioner's specialty. The board may not designate a practitioner as nonpayable in the absence of the committee's recommendation to do so. All reports,

data, and proceedings of the corporation relative to a practitioner who is considered for designation as nonpayable is confidential, and may not be disclosed or be subject to subpoena or other legal process. The corporation may not pay or reimburse claims of its members relating to a treatment or service that is provided by a practitioner who is designated nonpayable. Nonpayable status under this section may not commence until after appropriate notification to the corporation's subscribers and the affected practitioner.

3. All practitioners in a group practice shall elect participating or nonparticipating status, as a group, with the health service corporation. If a practitioner is designated as nonparticipating or nonpayable under this section, the participating or nonparticipating status of the group is not affected. "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association.

4. A health service corporation may, in its discretion, by its articles of incorporation, articles of association, or bylaws, and in its contract with its subscribers, limit the benefits that the corporation will furnish, and may provide for a division of benefits it agrees to furnish into classes or kinds. In the absence of any limitation or division of services, a corporation may provide both general and special medical and surgical, dental, or optometric care benefits, including such service as may necessarily be incident to such care. A corporation may, in its discretion, limit the issuance of contracts as specified in its bylaws.

5. A dental or optometric service contract by a health service corporation may not provide the payment of any cash indemnification by the corporation to the subscriber or the subscriber's estate on account of death, illness, or other injury.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 299

SENATE BILL NO. 2390
(Senator Lindgren)
(Representative Kelsch)

NONPARTICIPATING PHYSICIAN PAYMENT

AN ACT to amend and reenact section 26.1-17-16 of the North Dakota Century Code, relating to services of practitioners not participating under health service plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-16 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-16. Services of physicians, oral surgeons, dentists, and practitioners not participating under health service plan. A medical service plan may provide for medical services to subscribers by physicians and oral surgeons not participating under the plan, subject to the approval of the board of directors of the health service corporation. A dental service plan may provide for dental services to subscribers by dentists not participating under the plan, subject to the approval of the board of directors of the health service corporation. An optometric service plan may provide for optometric services to subscribers by practitioners not participating under the plan, subject to the approval of the board of directors of the health service corporation.

Where a subscriber patient is referred by a participating physician to a nonparticipating physician, the health service corporation is to pay, without the approval of the board of directors of the corporation, to the subscriber, upon proper filing of the claim, an amount equal to ~~the amount lawfully charged for the service performed by the nonparticipating physician, but not to exceed an amount equal to one hundred~~ ninety percent of the maximum amount which the corporation would be obligated to pay to a participating physician for identical service. If a participating physician refers a patient to a nonparticipating physician, the referring physician shall inform the patient that the physician to whom the referral is being made is nonparticipating and this may result in the patient being subject to charges greater than those to which the patient would be subject if the patient were being treated by a participating provider. The health service corporation shall provide a listing of all participating physicians to all participating physicians annually. The corporation shall provide monthly updates of the listing of the nonparticipating providers.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 300

SENATE BILL NO. 2226
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS

AN ACT to create and enact chapter 26.1-17.1 of the North Dakota Century Code, relating to prepaid limited health service organizations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-17.1 of the North Dakota Century Code is created and enacted as follows:

26.1-17.1-01. Definitions. As used in this chapter, unless otherwise defined in this chapter:

1. "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this chapter.

2. "Evidence of coverage" means the certificate, agreement, or contract issued pursuant to section 26.1-17.1-08 setting forth the coverage to which an enrollee is entitled.

3. "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service may not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health services set forth in the preceding sentence.

4. "Net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner.

5. "Prepaid limited health service organization" means any corporation, partnership, or other entity which, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Prepaid limited health service organization does not include:

   a. An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

   b. An entity that meets the requirements of section 26.1-17.1-06; or

   c. A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited

health service organization or with an entity described in subdivision a or b.

6. "Provider" means any physician, dentist, health facility, or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services.

7. "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this chapter.

8. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going-concern value; organizational expense; startup costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due.

9. "Uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health services organization for which an enrollee may be liable in the event of the insolvency of the organization and for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, must be considered a covered expense.

26.1-17.1-02. Certificate of authority required. A person, corporation, partnership, or other entity may not operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this chapter.

26.1-17.1-03. Application for certificate of authority. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the commissioner on a form prescribed by the commissioner. Such application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

1. A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to such documents.

2. A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.

3. A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent or more of the voting securities

of the applicant, and the partners or members in the case of a partnership or association.

4. A statement generally describing the applicant, its facilities, personnel, and the limited health service or services to be offered.

5. A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees.

6. A copy of the form of any contract made or to be made between the applicant and any person listed in subsection 3.

7. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions including the following:

   a. Marketing and enrollment.

   b. Administration.

   c. Investment management.

   d. Subcontracting for the provision of the limited health service to enrollees.

8. A copy of the form of any contract which is to be issued to employers, unions, trustees, or other organizations or individuals and a copy of any form of evidence of coverage to be issued to subscribers or enrollees.

9. A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which will be consolidating financial statements of the applicant, satisfies this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this chapter.

10. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies.

11. A schedule of rates and charges.

12. A description of the proposed method of marketing.

13. A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served upon the commissioner.

14. A description of the complaint procedures to be established and maintained as required under section 26.1-17.1-12.

15. A description of the quality assessment and utilization review procedures to be utilized by the applicant.

16. A description of how the applicant will comply with section 26.1-17.1-17.

17. The fee for issuance of a certificate of authority provided in section 26.1-17.1-23.

18. Such other information as the commissioner may reasonably require to make the determinations required by this chapter.

26.1-17.1-04. Issuance of certificate of authority - Denial.

1. Following receipt of an application filed pursuant to section 26.1-17.1-03, the commissioner shall review such application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

   a. The requirements of section 26.1-17.1-03 have been fulfilled.

   b. The individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education.

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

      (1) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith.

      (2) The adequacy of working capital, other sources of funding, and provisions for contingencies.

      (3) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization.

      (4) The manner in which the requirements of section 26.1-17.1-17 have been fulfilled.

   d. The agreements with providers for the provision of limited health services contain the provisions required by section 26.1-17.1-16.

   e. Any deficiencies identified by the commissioner have been corrected.

2. If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The

applicant has thirty days from the date of receipt of the notice to request a hearing before the commissioner pursuant to chapter 28-32.

26.1-17.1-05. Effect on organizations operating on effective date of this chapter. Within ninety days after the effective date of this Act, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

26.1-17.1-06. Filing requirements for authorized entities.

1. Any entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital, or medical service corporation, or a fraternal benefit society and which is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by subsections 4, 5, 7, 8, 10, 11, 12, and 15 of section 26.1-17.1-03 and any subsequent material modification or addition thereto.

2. Following approval by the commissioner of the filing in subsection 1, and upon application by the entity and surrender of its original certificate of authority, the commissioner may issue a new certificate of authority under this chapter. The entity will be subject to the capitalization requirements under its original certificate of authority and the net equity and deposit provisions of section 26.1-17.1-17 do not apply.

3. If the commissioner disapproves the filing, the procedures set forth in subsection 2 of section 26.1-17.1-04 must be followed.

26.1-17.1-07. Changes in rates and benefits and material modifications - Addition of limited health services.

1. A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges, or benefits and of any material modification of any matter or document furnished pursuant to section 26.1-17.1-03, together with such supporting documents as are necessary to fully explain the change or modification.

2. If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by section 26.1-17.1-03 and shall demonstrate compliance with sections 26.1-17.1-16, 26.1-17.1-17, and 26.1-17.1-23.

3. A change or modification filed with the commissioner pursuant to subsections 1 and 2 may be used by the prepaid limited health service organization only after approval by the commissioner or upon the expiration of sixty days from the date of filing.

4. If such filings are disapproved, the commissioner shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization has thirty days from the date of receipt of notice to request a hearing before the commissioner pursuant to chapter 28-32.

26.1-17.1-08. Evidence of coverage.

1. Every subscriber must be issued an evidence of coverage, which must contain a clear and complete statement of:

   a. The limited health services to which each enrollee is entitled.

   b. Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment, or other charges.

   c. Where and in what manner information is available as to where and how services may be obtained.

   d. The method for resolving complaints.

2. Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

26.1-17.1-09. Rates and charges. The rates and charges must be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

26.1-17.1-10. Construction with other laws.

1. a. A prepaid limited health service organization organized under the laws of this state must be deemed to be a domestic insurer for purposes of chapter 26.1-10 unless specifically exempted in writing from one or more of the provisions of such act by the commissioner.

   b. A prepaid limited health service organization is subject to chapter 26.1-04.

   c. No other provision of the insurance code applies to a prepaid limited health service organization unless such an organization is specifically mentioned therein, or unless otherwise provided in this chapter.

2. The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this chapter may not be deemed to be the practice of medicine or other healing arts.

3. Solicitation to arrange for or provide limited health services in accordance with this chapter may not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

26.1-17.1-11. Nonduplication of coverage. Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or

medical service corporation, or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, insofar as the coverage or service is provided in accordance with this chapter under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation, or a fraternal benefit society.

26.1-17.1-12. Complaint system. Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein may be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

26.1-17.1-13. Examination of organization.

1. For purposes of examination, expenses of examination, and tax credits therefor, each prepaid limited health service organization is subject to the laws applicable to insurance companies.

2. In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner of another state.

26.1-17.1-14. Investments. The funds of a prepaid limited health service organization may be invested only in accordance with the laws and rules applicable to insurance companies.

26.1-17.1-15. Agents. No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise duly authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

26.1-17.1-16. Contracts with providers. All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis must contain or must be construed to contain the following terms and conditions:

1. In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of this contract, the enrollees are not liable to the provider for any sums owed to the provider under this contract.

2. No provider, agent, trustee, or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.

3. These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

4. These provisions survive the termination of this contract, regardless of the reason giving rise to termination.

5. Termination of this contract does not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed sixty days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of this contract.

6. Any amendment to these foregoing provisions of this contract must be submitted to and be approved by the commissioner prior to becoming effective.

26.1-17.1-17. Protection against insolvency - Deposit.

1. a. Except as approved in accordance with subsection 3, each prepaid limited health service organization shall, at all times, have and maintain tangible net equity equal to the greater of:

   (1) Fifty thousand dollars; or

   (2) Two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

   b. A prepaid limited health service organization that has uncovered expenses in excess of fifty thousand dollars, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to twenty-five percent of the uncovered expense in excess of fifty thousand dollars in addition to the tangible net equity required by subdivision a of subsection 1.

2. a. Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner in an amount equal to twenty-five thousand dollars plus twenty-five percent of the tangible net equity required in subsection 1; provided, however, that the deposit may not be required to exceed one hundred thousand dollars.

   b. The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

   c. All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities must be approved by the commissioner before being substituted.

   d. The deposit must be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.

e. The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

3. The commissioner may waive the requirements of subsections 1 and 2 upon a finding that:

   a. The prepaid limited health service organization has a net equity of at least five million dollars; or

   b. An entity having a net equity of at least five million dollars furnishes to the commissioner a written commitment, which is acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

26.1-17.1-18. Officers and employees fidelity bond.

1. A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than fifty thousand dollars or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state shall satisfy the requirements of this subsection.

2. In lieu of the bond specified in subsection 1, a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in section 26.1-17.1-14. Such a deposit must be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

26.1-17.1-19. Reports.

1. Every prepaid limited health service organization shall file with the commissioner annually, on or before March first, a report verified by at least two principal officers covering the preceding calendar year.

2. Such report must be on forms prescribed by the commissioner and must include:

   a. A financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which must be consolidating financial statements of the prepaid limited health service organization.

b. The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year.

c. Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the duties under this chapter.

3. The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out the duties under this chapter.

4. The commissioner may assess a fine of up to one hundred dollars per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

26.1-17.1-20. Suspension or revocation of certificate of authority.

1. The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this chapter upon determining that any of the following conditions exist:

a. The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to section 26.1-17.1-03, unless amendments to such submissions have been filed and authorized pursuant to section 26.1-17.1-07.

b. The prepaid limited health service organization issues an evidence of coverage or uses rates or charges which do not comply with the requirements of sections 26.1-17.1-08 and 26.1-17.1-09.

c. The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services.

d. The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

e. The tangible net equity of the prepaid limited health service organization is less than that required by section 26.1-17.1-17 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner.

f. The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by section 26.1-17.1-12.

g. The continued operation of the prepaid limited health service organization would be hazardous to its enrollees.

h. The prepaid limited health service organization has otherwise failed to comply with this chapter.

2. If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty days thereafter for a hearing on the matter in accordance with chapter 28-32.

3. When the certificate of authority of a prepaid limited health service organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of the enrollees, to the end that the enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

26.1-17.1-21. Penalties. In lieu of any penalty specified elsewhere in this chapter, or when no penalty is specifically provided, whenever any prepaid limited health service organization or other person, corporation, partnership, or entity subject to this chapter has been found after hearing to have violated any provision of this chapter, the commissioner may:

1. Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of such findings and an order requiring such organization, person, or entity to cease and desist from engaging in the act or practice which constitutes the violation.

2. Impose a monetary penalty of not more than one thousand dollars for each violation, but not to exceed an aggregate penalty of ten thousand dollars.

26.1-17.1-22. Rehabilitation, conservation, or liquidation.

1. Any rehabilitation, conservation, or liquidation of a prepaid limited health service organization must be deemed to be the rehabilitation, conservation, or liquidation of an insurance company and must be conducted pursuant to chapter 26.1-06.1.

2. Prepaid limited health service organizations are not subject to chapter 26.1-38.1, nor do the protections provided by chapter 26.1-38.1 apply to any individuals entitled to receive limited health services from a prepaid limited health service organization.

26.1-17.1-23. Fees. Every prepaid limited health service organization is subject to the fees set out in section 26.1-01-07.

26.1-17.1-24. Confidentiality.

1. Any information pertaining to the diagnosis, treatment, or health of any enrollee obtained from such person or from any provider by any prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this chapter must be held in confidence and may not be disclosed to any person except:

a. To the extent that it may be necessary to carry out the purposes of this chapter;

b. Upon the express consent of the enrollee or applicant, provider, or prepaid limited health service organization, as appropriate;

c. Pursuant to statute or court order for the production of evidence or the discovery thereof; or

d. In the event of claim or litigation wherein such data or information is relevant.

2. With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization is entitled to claim any statutory privileges against disclosure which the provider who furnished such information to the prepaid limited health service organization is entitled to claim.

3. In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination must be held in confidence.

26.1-17.1-25. Taxes. Every prepaid limited health service organization is subject to the tax provided in section 26.1-03-17 as it pertains to health maintenance organizations, and each prepaid limited health service organization is entitled to the same tax deductions, reductions, abatements, and credits that health maintenance organizations are entitled to receive.

26.1-17.1-26. Rulemaking. The commissioner may adopt reasonable rules necessary in the implementation of this chapter.

Approved March 31, 1993
Filed April 1, 1993

CHAPTER 301

HOUSE BILL NO. 1046
(Legislative Council)
(Interim Legislative Audit and Fiscal Review Committee)

BOILER INSPECTION DUTIES TRANSFER

AN ACT to transfer boiler inspection duties from the workers compensation bureau to the commissioner of insurance as manager of the state fire and tornado fund; and to repeal chapter 65-12 of the North Dakota Century Code, relating to boiler inspection.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definition. As used in this Act, unless the context otherwise requires "boiler" means a closed vessel in which water is heated, steam is generated, steam is superheated, or any combination thereof, under pressure or vacuum for use externally to the boiler by the direct application of heat from the combustion of fuels, or from electricity or nuclear energy. The term includes fired units for heating or vaporizing liquids other than water where these units are separate from processing systems and are complete within themselves.

SECTION 2. Chief boiler inspector, deputy inspectors - Appointment - Jurisdiction. The commissioner, as manager of the state fire and tornado fund, shall employ a chief boiler inspector and deputy inspectors. The chief boiler inspector has jurisdiction over all boilers in this state except as otherwise provided.

SECTION 3. Qualifications of chief boiler inspector - Deputy inspectors.

1. No person is eligible to the office of chief boiler inspector unless that person:

   a. Has had at the time of the appointment at least five years' experience in the construction, inspection, operation, maintenance, or repair of high pressure boilers and pressure vessels as a mechanical engineer, boilermaker, steam operating engineer, or boiler inspector. An applicant possessing a mechanical engineering degree from an accredited school may substitute that degree for two years of the five years' experience, at the discretion of the commissioner.

   b. Holds a commission issued by the national board of boiler and pressure vessel inspectors or obtains the commission within one year after the date of appointment by the commissioner.

   c. Is not directly or indirectly interested in the manufacture or sale of boilers or steam machinery or articles used in the construction or maintenance of engines or boilers.

2. The commissioner shall establish qualifications for a deputy inspector which are not inconsistent with the requirements of the position.

SECTION 4. Powers and duties of chief boiler inspector.

1. The chief boiler inspector shall:

   a. Keep a complete record of the type, dimensions, maximum allowable working pressure, age, condition, location, and date of the last recorded internal and external inspection of boilers to which this Act applies.

   b. Cooperate and assist in loss prevention programs sponsored by the commissioner.

2. The chief boiler inspector may delegate powers and duties to any deputy inspector or special inspector.

SECTION 5. General requirement. Every boiler in this state must be constructed, installed, and maintained according to rules adopted to implement this Act.

SECTION 6. Exempt boilers - Inspection of exempt boilers. This Act does not apply to:

1. Any boiler subject to federal inspection or under federal control.

2. Any boiler located on a farm and used solely for agricultural purposes.

3. Any heating boiler located in a private residence or in an apartment house of less than six family units.

4. Any hot water supply boiler not exceeding the following limitations:

   a. Input of two hundred thousand British thermal units per hour.

   b. Pressure of one hundred sixty pounds [72.57 kilograms] per square inch [6.45 square centimeters] gauge.

   c. Temperature of two hundred fifty degrees Fahrenheit [121.11 degrees Celsius].

5. Any portable steam cleaner commonly used in a garage.

6. Any boiler of a miniature model locomotive, boat, tractor, or stationary engine design constructed as a hobby, not for commercial use, having an inside diameter not exceeding ten inches [25.4 centimeters] and a grate area not exceeding one and one-half square feet [1393.54 square centimeters] and which is properly equipped with a safety valve, water level indicator, and pressure gauge.

SECTION 7. Inspection of boilers. The chief boiler inspector shall inspect each boiler used or proposed to be used within this state. The inspection must be thorough as to the construction, installation, condition, and operation as provided by the rules adopted to implement this Act. An exempt boiler may be inspected by the chief boiler inspector when the owner, the owner's agent, or the user of the boiler makes written request for inspection to the commissioner. Each boiler of one hundred thousand pounds [45359.24 kilograms] per hour or more capacity, used or proposed to be used within this state, which has internal continuous water treatment

under the direct supervision of a graduate engineer or chemist, or one having equivalent experience in the treatment of boiler water where the water treatment is for the purpose of controlling and limiting serious corrosion and other deteriorating factors, and with respect to which boiler the chief boiler inspector has determined that the owner or user has complied with the prescribed recordkeeping requirements, must be inspected at least once every twenty-four months internally and externally while not under pressure, and at least once every eighteen months externally while under pressure. If a hydrostatic test is necessary to determine the safety of a boiler, the test must be conducted by the owner or user of the equipment under the supervision of the chief boiler inspector. The owner or user of a boiler of one hundred thousand pounds [45359.24 kilograms] per hour or more capacity desiring to qualify for twenty-four months inspection shall keep available for examination by the chief boiler inspector accurate records showing the date and actual time the boiler is out of service and the reason or reasons therefor, and the chemical physical laboratory analysis of samples of the boiler water taken at regular intervals of not more than forty-eight hours of operation as will adequately show the condition of the water and any elements or characteristics of the water capable of producing corrosion or other deterioration of the boiler or its parts. In the event an inspection discloses deficiencies in equipment or in operating procedures, inspections may be required once every twelve months.

SECTION 8. Special inspector.

1. Upon written request of the employer, the commissioner may appoint as a special inspector an inspector in the employ of any insurance company authorized to insure boilers in this state against loss from explosion or any self-insured company that has employees for the purpose of inspecting its own boilers in this state. No person may be appointed as a special inspector unless that person has passed the examination prescribed by the national board of boiler and pressure vessel inspectors.

2. Every inspection made by a special inspector must be performed in accordance with this Act and a complete report of the inspection must be filed with the commissioner in the time, manner, and form as prescribed by the commissioner.

3. If a complete report is not filed with the commissioner within ninety days from the certificate due date, the chief boiler inspector may make the required inspection, unless extensions of time are granted by the chief boiler inspector. For that inspection, the insurance company or self-insured company shall pay all appropriate inspection fees in accordance with section 9 of this Act.

4. The chief boiler inspector may inspect any boiler to which a special inspection applies.

5. The commissioner may, for cause, suspend or revoke the appointment of any special inspector.

SECTION 9. Inspection fees. Upon completion of inspection, the owner or user of a boiler inspected by the chief boiler inspector shall pay to the commissioner fees or a combination of fees which must be determined annually by the commissioner. The commissioner may determine and annually adjust a fee scale for the internal inspection of power boilers, internal inspections of low pressure heating boilers,

external inspections of all boilers, and inspection of boilers used exclusively for exhibition purposes.

Not more than one hundred dollars may be charged or collected for the inspection of a boiler in a year except for special inspections made upon request. Not more than seventy-five dollars may be charged or collected for an inspection of a steam traction engine in a year except for special inspections made upon request. All other inspections made by the chief boiler inspector, including shop inspections and reviews and special inspections when requested by the owner or user of a boiler, must be charged at a rate not to exceed one hundred eighty-five dollars per day or one hundred dollars per half day of four hours or less, plus payment for mileage, meals, and hotel expenses as allowed by sections 44-08-04 and 54-06-09. The annual fee for the issuance of a reciprocal commission card for a special inspector is twenty dollars and the annual fee for the issuance of a welder-qualified card is ten dollars.

SECTION 10. Certificate of inspection - Certificate to be posted. The commissioner shall issue a certificate of inspection for each boiler inspected upon receipt of an inspection report certifying that the boilers are in a safe condition to be operated. The commissioner shall charge a fee of fifteen dollars for each certificate of inspection issued as the result of inspections authorized under section 8 of this Act. The fees are the liability of the insurance company or self-insured company and must be paid in accordance with rules adopted by the commissioner. No certificate may be issued for any boiler not in a safe condition to be operated. No certificate is valid for a period of more than twelve months for power boilers, twenty-four months for steam traction engines, and thirty-six months for low pressure boilers except that a two-month grace period may be extended for any certificate. Upon written request from a special inspector, the chief boiler inspector may issue a short-term certificate. Each certificate of inspection must be posted conspicuously under glass in the boilerroom or adjacent to the boiler inspected.

SECTION 11. Certificate of inspection required - Penalty. No person may operate a boiler in this state without a valid certificate of inspection. A violation of this section is a class A misdemeanor on the part of the owner, user, or operator of the boiler.

SECTION 12. Manufacturer's data report. The boiler manufacturer shall provide the commissioner with a manufacturer's data report. When signed by an authorized inspector, this data sheet together with the stamp on the boiler is the record denoting that the boiler has been constructed in accordance with the rules adopted to implement this Act.

SECTION 13. Disposition of funds. All funds collected and received under this Act must be paid to the state treasurer and deposited in the state fire and tornado fund to be used to defray the costs of boiler inspections. The commissioner shall not issue a certificate of inspection until all inspection fees have been paid in accordance with section 9 of this Act.

SECTION 14. Rules - Penalty for violation - Hearing. The commissioner shall adopt rules for the safe and proper installation, use, operation, and inspection of boilers and pressure vessels subject to this Act. The commissioner may not issue a certificate of inspection to any owner or user of a boiler who fails or refuses to comply with those rules. The commissioner shall revoke any certificate presently in

force upon evidence that the owner or user of the boiler is failing or refusing to comply with the rules.

Any owner or user of a boiler may request a hearing before the commissioner within fifteen days from service of an order refusing or revoking a certificate of inspection. It is the burden of the owner or user to show cause why the certificate of inspection should not be refused or revoked. If no hearing is requested within the required period, the order of the commissioner becomes final and is not subject to further proceedings.

SECTION 15. REPEAL. Chapter 65-12 of the North Dakota Century Code is repealed.

Approved March 22, 1993
Filed March 23, 1993

CHAPTER 302

HOUSE BILL NO. 1357
(Representatives Soukup, Bernstein, Cleary)
(Senators Lindaas, Nalewaja, Tomac)

AUTO INSURANCE PREMIUM REDUCTIONS

AN ACT to amend and reenact section 26.1-25-04.1 of the North Dakota Century Code, relating to the discounts from certain motor vehicle insurance premiums.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-25-04.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-04.1. Motor vehicle insurance rate filings - Premium reduction for accident prevention course completion. All rate filings with the commissioner for motor vehicle liability and physical damage insurance must provide for an appropriate reduction in premium charges for the principal operators of motor vehicles for at least a two-year period following their successful completion of a motor vehicle accident prevention course. The reduction in premium charges must be separately disclosed. The premium billing must disclose the reduction in premium charges with respect to the person eligible for the reduction. The reduction in premium charges does not apply to an operator who is subject to an experience rating or a driver education premium reduction. If a policy insures two or more motor vehicles, the premium reduction applies only to the motor vehicle principally operated by the person who has satisfactorily completed the motor vehicle accident prevention course. The course must be approved by the superintendent of the state highway patrol. The course sponsor shall provide each successful participant a certificate ~~which~~ that is the basis for the insurance discount. A driver fifty-five years of age or older who successfully completes an approved motor vehicle accident prevention course is entitled to a three-year insurance premium reduction. The reduction may be applied only to a private passenger motor vehicle or a pickup truck or van that has a gross vehicle weight of less than ten thousand pounds [4535.92 kilograms] and which is not used for delivering or transporting goods or materials unless the delivery and transport is incidental to an operator's business.

Approved April 9, 1993
Filed April 9, 1993

CHAPTER 303

SENATE BILL NO. 2225
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

AUTO INSURANCE SURCHARGE AND DECLINATION

AN ACT to create and enact two new sections to chapter 26.1-25 of the North Dakota Century Code, relating to accident surcharge; and to amend and reenact subsection 5 of section 26.1-40-11 of the North Dakota Century Code, relating to prohibited reasons for declinations of automobile insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Two new sections to chapter 26.1-25 of the North Dakota Century Code are created and enacted as follows:

Motor vehicle accident surcharge. Concerning motor vehicle accidents occurring after August 1, 1993:

1. An insurer may not assess an accident surcharge on the policy of any insured as a result of a comprehensive coverage claim or when the insured's unattended vehicle was legally parked when the damage occurred.

2. An insurer may not assess an accident surcharge on the policy of any insured when a claim has been paid pursuant to section 26.1-40-17.1 unless the insurer is not entitled to recover damages from the party at fault.

Disclosure of accident surcharge and loss of discount. Before, or at the time of issuance of a policy, an insurer insuring a motor vehicle must notify the insured in writing of the insurer's underwriting and rating procedures applicable to accident surcharges and loss of discounts.

SECTION 2. AMENDMENT. Subsection 5 of section 26.1-40-11 of the North Dakota Century Code is amended and reenacted as follows:

5. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism or an insurance company that insures substandard risks.

Approved April 12, 1993
Filed April 12, 1993

CHAPTER 304

HOUSE BILL NO. 1230
(Representatives Payne, Wald)
(Senators Lindgren, Tallackson)

INSURANCE AGENT EDUCATION EXEMPTION

AN ACT to amend and reenact subsection 1 of section 26.1-26-31.1 of the North Dakota Century Code, relating to continuing education requirements for insurance agents.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-26-31.1 of the North Dakota Century Code is amended and reenacted as follows:

1. Except as otherwise provided in this section, any person licensed as an insurance agent, insurance broker, surplus lines insurance broker, or insurance consultant shall provide the commissioner evidence, as required by the commissioner, that the person attended or participated in continuing education of not less than fifteen hours per year of approved coursework, of which seven and one-half hours per year must be classroom hours. The commissioner may waive the requirement of seven and one-half hours per year of classroom hours. The commissioner may reduce the minimum number of hours per year of approved coursework for any person having a license limited to a single line of insurance as described in section 26.1-26-11. The continuing education advisory task force may recommend granting up to fifteen hours continuing education credit for nationally recognized insurance education correspondence programs. The commissioner shall review the task force's recommendation, and the commissioner may approve up to fifteen hours of credit. Credit for courses attended in any one year over the minimum number of hours of coursework required may be credited to the year next preceding the year in which they were earned or to the year next following the year in which they were earned. Reports of continuing education must be made at the end of each two-year period following licensure. No continuing education is required of ~~a life insurance~~ an agent licensed for the sale of life insurance or sickness, accident, and health insurance, or both, who is at least sixty-two years of age, who has a combined total years of continuous licensure as such agent and years of age which equals eighty-five, and whose commissions from new business each year do not exceed ten thousand dollars. No continuing education is required of an insurance agent who sells only group credit life or group credit accident and health insurance to cover an indebtedness.

Approved April 19, 1993
Filed April 20, 1993

CHAPTER 305

HOUSE BILL NO. 1332
(Representative Svedjan)
(Senator DeMers)

HEALTH CARE UTILIZATION REVIEW

AN ACT to create and enact a new section to chapter 26.1-26.4 of the North Dakota Century Code, relating to health care utilization review; and to amend and reenact subsection 5 of section 26.1-26.4-02 and sections 26.1-26.4-03 and 26.1-26.4-04 of the North Dakota Century Code, relating to health care service utilization review.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 5 of section 26.1-26.4-02 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

5. "Utilization review agent" means any person or entity performing utilization review, except:

   a. An agency of the federal government; or

   b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services.

SECTION 2. AMENDMENT. Section 26.1-26.4-03 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-03. Certification. A utilization review agent may not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with section 26.1-26.4-04. Certification must be made annually on or before March first of each calendar year. In addition, a ~~certification~~ utilization review agent must file the following information:

1. The name, address, telephone number, and normal business hours of the utilization review agent~~;~~.
2. The name and telephone number of a person for the commissioner to contact~~; and~~.
3. A description of the appeal procedures for utilization review determinations.
4. A list of the third party payers for whom the private review agent is performing utilization review in the state.

A provider may request that a utilization review agent furnish the provider with the medical review criteria to be used in evaluating proposed or delivered health

care services. Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

SECTION 3. AMENDMENT. Section 26.1-26.4-04 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-04. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review.

2. Any determination by a utilization review agent as to the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or, if appropriate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist.

3. Any notification of a determination not to certify an admission or service or procedure must include the principal reason for the determination and the procedures to initiate an appeal of the determination.

4. Utilization review agents shall maintain and make available a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the utilization review agent. The appeal procedure must provide for the following:

   a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be made by a physician or, if appropriate, a licensed psychologist.

   b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures no later than thirty days from the date the appeal is filed and the receipt of all information necessary to complete the appeal.

   c. Utilization review agents shall provide for an expedited appeals process for emergency or life-threatening situations. Utilization review agents shall complete the adjudication of expedited appeals within forty-eight hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal.

5. Utilization review agents shall make staff available by toll-free telephone at least forty hours per week during normal business hours.

6. Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two working days.

7. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.

8. Physicians or psychologists making utilization review determinations shall have current licenses from a state licensing agency in the United States.

9. Utilization review agents shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for an enrollee or the enrollee's representative to notify the utilization review agent and request certification or continuing treatment for that condition.

10. When an initial appeal to reverse a determination is unsuccessful, a subsequent determination regarding hospital, medical, or other health care services provided or to be provided to a patient which may result in a denial of third party reimbursement or a denial of precertification for that service must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate.

However, the commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.

SECTION 4. A new section to chapter 26.1-26.4 of the 1991 Supplement to the North Dakota Century Code is created and enacted as follows:

Utilization review in this state - Conditions of employment. A utilization review agent is deemed to be conducting utilization review in this state if the agent conducts utilization review involving services rendered or to be rendered in the state regardless of where the agent actually performs the utilization review. No person may be employed or compensated as a private review agent under any agreement or contract where compensation of the review agent is contingent upon a denial or reduction in the payment for hospital, medical, or other health care services.

Approved April 1, 1993
Filed April 2, 1993

CHAPTER 306

HOUSE BILL NO. 1417
(Representative Gorman)

BAIL BONDS

AN ACT to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to bail bonds; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new chapter to title 26.1 of the North Dakota Century Code is created and enacted as follows:

Definition. "Bail bondsman" means any person who has been approved by the commissioner and appointed by an insurer by power of attorney to execute or countersign bail bonds for the insurer in connection with the judicial proceedings and charges and receives money for the services.

Licensing and continuing education requirements. The licensing and continuing education requirements under chapter 26.1-26 apply to bail bondsmen.

Persons disqualified as bail bondsmen - Violation is misdemeanor. The following persons or classes may not be bail bondsmen and may not directly or indirectly receive any benefits from the execution of any bail bond: jailers, police officers, committing magistrates, magistrate court judges, sheriffs, deputy sheriffs and constables, or any person having the power to arrest or having anything to do with the control of federal, state, county, or municipal prisoners. A violation of this section is a class B misdemeanor.

Unqualified and unlicensed person acting as bail bondsman prohibited - Pledging of property by individual as security for bail bond permitted - Violation is misdemeanor. No person may act in the capacity of a bail bondsman or perform any of the functions, duties, or powers prescribed for bail bondsmen under the provisions of this chapter unless that person is qualified and licensed as provided in this chapter. However, none of the provisions of this section prohibit any individual from pledging real or other property as security for a bail bond in judicial proceedings if the person does not receive, or is not promised, money or other things of value therefor. Violation of this section is a class B misdemeanor.

Violations - Penalties.

1. The commissioner may suspend, revoke, or refuse to continue, issue, or renew any license issued under this chapter if, after notice to the licensee and hearing, the commissioner finds as to the licensee any of the following conditions:

   a. Recommending any particular attorney at law to handle the case in which the bail bondsman has caused a bond to be issued under the terms of this chapter.

b. Forging the name of another to a bond or application for bond.

c. Soliciting business in or about any place for prisoners or confined, arraigned, or in custody.

d. Paying a fee or rebate, or giving or promising anything of value to a jailer, trustee, police officer or officer of the law, or any other person who has power to arrest or hold in custody or to any public official or public employee in order to secure a settlement, compromise, remission, or reduction of the amount of any bail bond or entreatment thereof, or to secure, delay, or other advantage. This does not apply to a jailer, police officer, or officer of the law who is not on duty and who assists in the apprehension of a defendant.

e. Paying a fee or rebating or giving anything of value to an attorney in bail bond matters, except in defense of any action on a bond.

f. Accepting anything of value from a principal other than a premium. Provided, the bondsman may accept collateral security or other indemnity from the principal which must be returned immediately upon final termination of liability on the bond. Such collateral security or other indemnity required by the bondsman must be reasonable in relation to the amount of the bond.

g. Willful failure to return collateral security to the principal when the principal is entitled thereto.

h. Knowingly employing a person whose agent license has been revoked, suspended, or denied in this or any other state.

i. Knowingly or intentionally executing a bail bond without collecting in full a premium therefor, at the premium rate as filed with and approved by the commissioner.

j. Failing to pay any forfeiture as directed by a court and as required by this title.

2. A bail bondsman or bail bond agency may not advertise as or hold itself out to be a surety company.

3. A bail bondsman may not sign nor countersign any blank in any bond, nor give up power of attorney to or otherwise authorize, anyone to countersign the bail bondsman's name to bonds.

4. When a bondsman accepts collateral, the bondsman shall give a written receipt for the collateral and this receipt must contain a full description of the collateral received in the terms of redemption. The bondsman shall keep copies of all receipts of the bonds to be placed in business to be available to the commissioner for the commissioner's review.

5. The provisions and penalties under this section are in addition to those provided under chapter 26.1-26.

Access to jails. Every person who holds a valid bail bondsman license issued by the insurance commissioner is entitled to equal access to the jails of the state

for the purpose of making bond, subject to the provisions of this chapter and the rules adopted in the manner provided by law. Jail personnel, law enforcement officers, and court personnel may not suggest, recommend, advise, or promote a particular bondsman. Each jail shall furnish a space convenient to the telephones in the booking area to be used to hold business cards of bondsmen.

Surrender of defendant prior to breach. At any time before there has been a breach of the undertaking in any type of bail provided herein, the surety or bondsman may surrender the defendant, or the defendant may surrender, to the official to whose custody the defendant would have been given had the defendant been committed. The defendant may be surrendered without the return of premium for the bond if the defendant has been guilty of nonpayment of premium, changing address without notifying the bondsman, self concealment, or leaving the jurisdiction of the court without the permission of the bondsman, or of violating his contract with the bondsman in any way that does harm to the bondsman, or the surety, or violates the obligation to the court. For the purpose of surrendering the defendant, the surety may arrest the defendant before the forfeiture of the undertaking, or by written authority endorsed on a certified copy of the undertaking, may empower any peace officer to make arrest, first paying the lawful fees therefor.

Maximum commission or fee. A professional bondsman may not charge a premium, commission, or fee in an amount more than ten percent of the amount of bail furnished by the bondsman, or fifty dollars, whichever is greater.

Failure to appear. If a defendant fails to appear for a scheduled court appearance, the clerk of court will notify the bondsman. If the bondsman returns the defendant to the jurisdiction of the court, the bondsman may petition the court for a return of the forfeiture, less five percent for court costs.

Rules. The commissioner may adopt reasonable rules for implementation and administration of this chapter.

Approved April 9, 1993
Filed April 9, 1993

CHAPTER 307

SENATE BILL NO. 2328
(Senators Urlacher, Robinson)
(Representatives A. Olson, Wald)

ANNUITY CONTRACTS

AN ACT to create and enact a new subsection to section 26.1-34-01 of the North Dakota Century Code, relating to required annuity contract provisions.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-34-01 of the North Dakota Century Code is created and enacted as follows:

A statement that when an annuity contract becomes a claim by the death of the annuitant, settlement:

a. If payable in one sum, must be made upon due proof of death, or not later than two months after receipt of the proof, and must include reasonable interest accrued from the date of death; or

b. If made under a settlement option other than subdivision a, must include reasonable interest accrued from date of death until such option is made according to the provisions of the contract.

As used in this subsection, the term "reasonable interest" means the same rate of interest as paid on death proceeds left on deposit with the insurer.

Approved April 15, 1993
Filed April 15, 1993

CHAPTER 308

SENATE BILL NO. 2479
(Senators Yockim, Evanson, Mathern)
(Representatives Dalrymple, Gulleson, Porter)

MENTAL DISORDER INSURANCE SERVICES

AN ACT to amend and reenact subsection 2 of section 26.1-36-09 of the North Dakota Century Code, relating to group health policy and service contract mental disorder coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-36-09 of the North Dakota Century Code is amended and reenacted as follows:

2. a. The benefits must be provided for inpatient treatment and treatment by partial hospitalization and outpatient treatment~~:~~.

~~a.~~ b. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of sixty days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined in subsection 25 of section 52-01-01 and the state department of health and consolidated laboratories' rules pursuant thereto offering treatment for the prevention or cure of mental disorder or other related illness.

~~b.~~ c. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined in subsection 25 of section 52-01-01 and the state department of health and consolidated laboratories' rules pursuant thereto or by a regional human service center licensed under section 50-06-05.2, offering treatment for the prevention or cure of mental disorder or other related illness. For services provided in regional human service centers, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

~~c.~~ d. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization; provided, however, that no more than forty-six days of the inpatient treatment benefits required by this section may be traded for treatment by partial hospitalization.

~~d.~~ e. (1) In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of thirty hours for services covered under this section in any calendar year if the treatment services are provided within the scope of licensure by

a nurse who holds advanced licensure with a scope of practice within mental health or if the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, or a licensed certified social worker who ~~is a board certified diplomate in clinical social work, or the treatment services are provided within the scope of licensure by a nurse who holds advanced licensure with a scope of practice within mental health.~~:

(a) Possesses a master's or doctorate degree in social work from an institution accredited by the council of social work education;

(b) Has at least one year of direct clinical social work practice during graduate school or one year of postgraduate supervised clinical social work practice in a structured teaching environment;

(c) Has at least seven thousand five hundred hours of post social work graduate degree clinical social work experience obtained within five years with at least three thousand hours direct clinical social work practice within the last ten years;

(d) Has at least three thousand hours post social work graduate degree supervised practice experience obtained within two years, one thousand five hundred hours of which must have been under the supervision of a qualified clinical social worker; and

(e) If not licensed in this state, is licensed, certified, or registered at the highest level of social work practice in another state.

(2) Upon the request of an insurance company, a nonprofit health service corporation, or a health maintenance organization the North Dakota board of social work examiners shall provide to the requesting entity information to certify that a licensed certified social worker meets the qualifications required under this section.

(3) The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five hours in any calendar year, and may not establish a copayment greater than twenty percent for the remaining hours.

f. "Partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 309

HOUSE BILL NO. 1485
(Representative Stenehjem)
(Senators W. Stenehjem, B. Stenehjem)

INSURANCE BENEFIT COORDINATION

AN ACT to amend and reenact sections 26.1-36-10 and 26.1-36-29 of the North Dakota Century Code, relating to coordination of accident and health insurance benefits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-10. ~~Group health~~ Health policy and health service contract coordination of benefit provisions. A group health insurance policy or a group health service contract may contain coordination of benefit provisions for the control of overinsurance. An individual health insurance policy or individual health service contract, except a specific disease, hospital indemnity, or other limited benefit plan, may contain coordination of benefit provisions for the control of overinsurance. These provisions must be in accordance with appropriate guidelines set forth in rules adopted by the commissioner.

SECTION 2. AMENDMENT. Section 26.1-36-29 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36-29. Coordination of benefits in individual and group accident and health policies - Limitations. An insurer or health service corporation may not issue or renew any individual or group accident and health insurance policy that excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued contract or plan of insurance which provides exclusively for ~~accident and health~~ specific disease, hospital indemnity, and other limited benefits, irrespective of the mode or channel of premium payment, with or without payroll deduction, to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of the insured's status as an employee. This section does not affect the practice of coordination of benefits ~~between group policies~~ as provided in section 26.1-36-10.

Approved April 8, 1993
Filed April 9, 1993

CHAPTER 310

SENATE BILL NO. 2206
(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE

AN ACT to create and enact a new section to chapter 26.1-45 of the North Dakota Century Code, relating to immunity from liability for volunteers of insurance counseling programs; and to amend and reenact subsection 4 of section 26.1-36.1-01, section 26.1-36.1-02, subsections 1 and 3 of section 26.1-36.1-05, subsection 4 of section 26.1-45-01, section 26.1-45-05.1, and subsection 1 of section 26.1-45-09 of the North Dakota Century Code, relating to medicare supplement insurance, long-term care insurance, and right to return a policy.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 4 of section 26.1-36.1-01 of the 1992 Special Supplement to the North Dakota Century Code is amended and reenacted as follows:

4. "Medicare supplement policy" means a group or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization or preferred provider organization, other than a policy issued pursuant to a contract under section 1876 or 1833 of the federal Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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. The term does not include~~:~~

   ~~a.~~ ~~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 the 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 the policy or plan to its members.~~

SECTION 2. AMENDMENT. Section 26.1-36.1-02 of the 1992 Special Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36.1-02. Standards for medicare supplement policies.

1. The commissioner shall adopt reasonable rules to establish specific standards for provisions of medicare supplement policies. The standards are in addition to and in accordance with applicable laws of this state, and may include coverage of:

   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. Definition of terms.

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

3. Notwithstanding any other law, a medicare supplement policy or certificate 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 or certificate 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.

4. ~~A policy or certificate of insurance providing medicare supplement benefits which is sold to a consumer to replace another medicare supplement policy or certificate may not contain any provision limiting payment of benefits due to preexisting conditions of the insured except if there is any time period remaining relating to the exclusion of coverage for preexisting conditions as specified in the underlying policy that remaining waiting period for coverage of preexisting conditions applies to the new policy unless the policy otherwise provides.~~

~~5.~~ No medicare supplement insurance policy, contract, or certificate in force in the state may contain benefits that duplicate benefits provided by medicare.

SECTION 3. AMENDMENT. Subsections 1 and 3 of section 26.1-36.1-05 of the 1991 Supplement to the North Dakota Century Code are amended and reenacted as follows:

1. To provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate may be delivered or issued for delivery in this state ~~and no certificate may 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.

3. The commissioner 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 may require by rule that the information brochure be provided to any prospective insureds eligible for medicare concurrently with the delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner 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.

SECTION 4. AMENDMENT. Subsection 4 of section 26.1-45-01 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

4. "Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered, or designed to provide coverage for not less than one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual policies or riders, whether issued by insurers, fraternal benefit societies, nonprofit health service corporations, prepaid health plans, health maintenance organizations, or any similar entity, which provide directly or which supplement long-term care insurance. The term also includes home health care type insurance policies or riders which provide directly or which supplement long-term care insurance; and include a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term does not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expenses coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as a long-term care insurance is subject to the provisions of this chapter.

SECTION 5. AMENDMENT. Section 26.1-45-05.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-05.1. Rescission of long-term care insurance policy or certificate. An insurer may not rescind a long-term care insurance policy or certificate or deny a claim on the basis of representations made by an insured on the application for insurance after ~~it~~ coverage has been in effect for six months except upon a showing by the insurer that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

SECTION 6. AMENDMENT. Subsection 1 of section 26.1-45-09 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. Long-term care insurance applicants have the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in subdivision a of subsection 3 of section 26.1-45-01, the applicant is not satisfied for any reason.

SECTION 7. A new section to chapter 26.1-45 of the North Dakota Century Code is created and enacted as follows:

Insurance counseling programs - Volunteers - Immunity from liability. A person who, on a volunteer basis, provides services or performs duties on behalf of the commissioner of insurance for an insurance counseling program is immune from civil liability for any act or omission resulting in damage or injury if at the time of the act or omission the person who caused the damage or injury was acting in good faith, in the exercise of reasonable and ordinary care, and in the scope of that person's duties as a volunteer and the act or omission did not constitute willful misconduct or gross negligence. This section does not grant immunity to a person causing damage as a result of the negligent operation of a motor vehicle.

Approved March 24, 1993
Filed March 25, 1993

CHAPTER 311

HOUSE BILL NO. 1504
(Representatives Wald, Mahoney, Monson, Payne)
(Senators Krauter, Tallackson)

SMALL EMPLOYER AND GROUP HEALTH COVERAGE

AN ACT relating to group health care coverage and small employer employee health insurance coverage; to create and enact two new sections to chapter 26.1-36 of the North Dakota Century Code, relating to copayments, prenatal and children's preventive health services, and loss ratios; to amend and reenact section 26.1-36-37.1 of the North Dakota Century Code, relating to a standard health insurance proof of loss form; and to repeal chapter 26.1-36.2 of the North Dakota Century Code, relating to small employer employee health insurance coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in sections 1 through 12 and section 16 of this Act, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the commissioner of insurance, that a small employer carrier is in compliance with section 4 of this Act, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

3. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

4. "Basic health benefit plan" means a lower cost health benefit plan developed under section 8 of this Act.

5. "Board" means the board of directors of the program established under section 7 of this Act.

6. "Carrier" means any entity that provides health insurance in this state. The term includes an insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

7. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.

8. "Class of business" means all or a separate grouping of small employers established under section 3 of this Act.

9. "Committee" means the health benefit plan committee created under section 8 of this Act.

10. "Control" is as defined in section 26.1-10-01.

11. "Dependent" means a spouse, an unmarried child under the age of nineteen, an unmarried child who is a full-time student under the age of twenty-three and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent as set forth in section 26.1-36-22.

12. "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

13. "Enrollee" means a person covered under a small employer health benefit plan.

14. "Established geographic service area" means a geographic area, as approved by the commissioner of insurance and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

15. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract. The term does not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

b. "Health benefit plan" does not include a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance, if the carrier offering that policy or certificate:

(1) Files with the commissioner of insurance on or before March first of each year a certification that contains:

(a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(b) A summary description of the policy or certificate, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender, or other factors) charged for the policy and certificate in this state.

(2) When the policy or certificate is offered for the first time in this state on or after the effective date of this Act, files with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

16. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

17. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:

a. The individual:

(1) Was covered under qualifying previous coverage at the time of the initial enrollment;

(2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and

(3) Requests enrollment within ninety days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

18. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

19. "Plan of operation" means the plan of operation of the program established under section 7 of this Act.

20. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

21. "Producer" means insurance agent or insurance broker.

22. "Program" means the state small employer carrier reinsurance program created under section 7 of this Act.

23. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under one or more of the following:

    a. Medicare or medicaid.

    b. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

    c. An individual health insurance policy, including coverage issued by a health maintenance organization, nonprofit health service corporation, and fraternal benefit society that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least one year.

24. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

25. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.

26. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.

27. "Small employer" means any person that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, must be considered one employer.

28. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

29. "Standard health benefit plan" means a health benefit plan developed under section 8 of this Act.

SECTION 2. Applicability and scope.

1. Sections 1 through 12 and section 16 of this Act apply to any health benefit plan that provides coverage to the employees of a small employer in this state if:

   a. Any portion of the premium or benefits is paid by or on behalf of the small employer;

   b. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

   c. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the United States Internal Revenue Code.

2. a. Except as provided in subdivision b, carriers that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier and any restrictions or limitations imposed by sections 1 through 12 and section 16 of this Act apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier.

   b. An affiliated carrier that is a health maintenance organization having a certificate of authority may be considered to be a separate carrier for the purposes of sections 1 through 12 and section 16 of this Act.

   c. Unless otherwise authorized by the commissioner, a small employer carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if the arrangements would result in less than fifty percent of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

3. a. A Taft Hartley trust, or a carrier with the written authorization of that trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of subsection 1 of section 4 of this Act with respect to a health benefit plan provided to the trust.

   b. The commissioner may grant the waiver if the commissioner finds that application of subsection 1 of section 4 of this Act, with respect to the trust:

      (1) Would have a substantial adverse effect on the participants and beneficiaries of that trust; and

      (2) Would require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

   c. A waiver granted under this section does not apply to a person who participates in the trust as an associate member of an employee organization.

SECTION 3. Establishment of classes of business.

1. A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs resulting from:

   a. The small employer carrier using more than one type of system for the marketing and sale of health benfit plans to small employers.

   b. The small employer carrier having acquired a class of business from another small employer carrier.

   c. The small employer carrier providing coverage to one or more association groups that meet the requirements set forth in rules adopted by the commissioner.

2. A small employer carrier may establish up to nine separate classes of business under subsection 1.

3. The commissioner may adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection 2 if the small employer carrier acquires an additional class of business from another small employer carrier.

4. The commissioner may approve the establishment of additional classes of business if the carrier applies to the commissioner and the commissioner determines that the action would enhance the efficiency and fairness of the small employer marketplace.

SECTION 4. Restrictions relating to premium rates.

1. Premium rates for health benefit plans subject to sections 1 through 12 and section 16 of this Act are subject to the following:

   a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than fifteen percent.

   b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to the employers under the rating system for that class of business, may not vary from the index rate by more than twenty percent of the index rate.

   c. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

      (1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which

the small employer carrier is actively enrolling new small employers;

(2) Any adjustment due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; however, the adjustment may not exceed fifteen percent annually and must be adjusted pro rata for rating periods of less than one year; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

d. Adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

e. Premium rates for health benefit plans must comply with the requirements of this section notwithstanding any assessment paid or payable by a small employer carrier pursuant to section 7 of this Act.

f. A small employer carrier may utilize industry as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

g. In the case of health benfit plans delivered or issued for delivery before the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in subdivisons a and b of subsection 1 for a period of three years following the effective date of this Act. Under this subdivision, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

h. (1) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce

premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(2) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

i. For the purposes of this subsection, a health benefit plan that uses a restricted provider network may not be considered similar coverage to a health benefit plan that does not use a restricted provider network, if the use of the restricted provider network results in substantial differences in claims costs.

j. A small employer carrier may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size, without prior approval of the commissioner.

k. The commissioner shall adopt rules to:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(2) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(3) Otherwise implement this section.

2. A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage.

3. The commissioner may suspend for a specified period the application of subdivision a of subsection 1 as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the small employer carrier or, with the prior approval of the committee established pursuant to section 8 of this Act, that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

4. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

a. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in

claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

b. The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

c. The provisions relating to renewability of policies and contracts; and

d. The provisions relating to any preexisting condition exclusion.

5. a. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

b. Each small employer carrier shall file with the commissioner on or before March fifteenth of each year an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification must be in a form and manner and contain information specified by the commissioner. The small employer carrier shall retain a copy of the certification at the carrier's principal place of business.

c. A small employer carrier shall make the information and documentation described in subdivision a of this subsection available to the commissioner upon request. Except in cases of violations of sections 1 through 12 and section 16 of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

SECTION 5. Renewability of coverage.

1. A health benefit plan subject to sections 1 through 12 and section 16 of this Act must be renewable with respect to all eligible employees and dependents, at the option of the small employer, except for any of the following:

a. Nonpayment of the required premiums.

b. Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives.

c. Noncompliance with the carrier's minimum participation requirements.

d. Noncompliance with the carrier's employer contribution requirements.

e. Repeated misuse of a provider network provision.

f. The small employer carrier electing to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In that case the carrier shall:

(1) Provide advance notice of its decision not to renew to the commissioner in each state in which it is licensed; and

(2) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under this paragraph must be provided at least three working days prior to the notice to the affected small employers.

g. The commissioner finds that the continuation of the coverage would not be in the best interests of the policy holders or certificate holders or would impair the carrier's ability to meet its contractual obligations. In this case the commissioner shall assist affected small employers in finding replacement coverage.

2. A small employer carrier that elects not to renew a health benefit plan under subdivision f of subsection 1 may not write new business in the small employer market in this state for a period of five years from the date of notice to the commissioner.

3. In the case of a small employer carrier doing business in one established geographic service area of the state, this section only applies to the carrier's operations in that service area.

SECTION 6. Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers at least two health benefit plans. Each small employer carrier shall offer one basic health benefit plan and one standard health benefit plan.

b. (1) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with sections 1 through 12 and section 16 of this Act.

(2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 3 of this Act, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan, are not related to the health

status or claim experience of the small employer, and are applied consistently to all small employers applying for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

c. A small employer is eligible under subdivision b if it employed at least three or more eligible employees within this state on at least fifty percent of its working days during the preceding calendar quarter.

d. This subsection takes effect one hundred eighty days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to section 8 of this Act; however, if the small employer health reinsurance program created pursuant to section 7 of this Act is not yet operative on that date, this section becomes effective on the date the program begins operation.

2. a. A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed under this subdivision may be used by a small employer carrier beginning sixty days after it is filed unless the commissioner disapproves its use.

b. The commissioner after providing notice and an opportunity for a hearing to the small employer carrier, may disapprove, at any time, the continued use by a small employer carrier of a basic or standard health benefit plan if the plan does not meet the requirements of sections 1 through 12 and section 16 of this Act.

3. Health benefit plans covering small employers must comply with the following:

a. A health benefit plan may not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan may not define a preexisting condition more restrictively than:

(1) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or

(2) A pregnancy existing on the effective date of coverage.

b. A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to the services, if the qualifying previous coverage was continuous until at least ninety days prior to the

effective date of the new coverage. The period of continuous coverage may not include a waiting period for the effective date of the new coverage applied by the employer or the carrier. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan.

c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

d. (1) Except as provided in this subdivision, a small employer carrier shall apply requirements used to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees who are applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (a) Except as provided in subparagraph b, a small employer carrier, in applying minimum participation requirements with respect to a small employer, shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.

(4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible

employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

4. a. A small employer carrier is not required to offer coverage or accept applications under subsection 1 if:

(1) A small employer who applies for coverage is not physically located in the carrier's established geographic service area;

(2) An employee who applies for coverage does not work or reside within the carrier's established geographic service area; or

(3) Within an area the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that, because of its obligations to existing group policyholders and enrollees, it will not have the capacity within its established geographic service area to deliver service adequately to the members of the groups.

b. A small employer carrier that cannot offer coverage pursuant to paragraph 3 of subdivision a may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees or to any small employer groups until the later of one hundred eighty days following each refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

5. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection 1 would place the small employer carrier in a financially impaired condition.

SECTION 7. Small employer carrier reinsurance program.

1. A nonprofit entity known as the North Dakota small employer health reinsurance program is created.

2. a. The program is subject to the supervision and control of the board. The board consists of eight members appointed by the commissioner of insurance and the commissioner or the commissioner's designated representative, who serves as an ex officio member of the board.

b. In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers and other individuals determined to be qualified by the commissioner. At least five of the members of the board must be representatives of reinsuring carriers and must be selected from individuals nominated by small employer carriers in this state under rules adopted by the commissioner.

c. The commissioner shall appoint the initial board members as follows: two members to serve a term of two years, three members to serve a term of four years, and three members to serve a term of six years.

Subsequent board members shall serve for a term of three years. A board member's term continues until a successor is appointed.

d. The commissioner shall appoint a person to fill a vacancy in the board. The commissioner may remove a board member for cause.

3. Within sixty days of the effective date of this Act, each small employer carrier shall file with the commissioner the carrier's total number of small employer group enrollees and its net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

4. Within one hundred eighty days after the appointment of the initial board, the board shall submit a plan of operation to the commissioner and the board also shall submit any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program to the commissioner. The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable, and equitable administration of the program and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with this section. The plan of operation is effective upon written approval by the commissioner.

5. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the commissioner, after notice and hearing, shall adopt a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this section when the board submits a plan of operation which the commissioner approves.

6. The plan of operation must establish procedures:

a. For handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

b. For selecting an administering carrier and setting forth the powers and duties of the administering carrier;

c. For reinsuring risks in accordance with this section;

d. For collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

e. For applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; and

f. For providing for any additional matters necessary for the implementation and administration of the program.

7. The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program may:

a. Enter into contracts as necessary or proper to carry out the provisions and purposes of sections 1 through 12 and section 16 of this Act, including with the approval of the commissioner, entering into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

b. Sue or be sued, including taking legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers or take any legal action necessary to avoid payment of improper claims against the program.

c. Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies under sections 1 through 12 and section 16 of this Act.

d. Establish rules for reinsuring risks under the program.

e. Assess reinsuring carriers in accordance with subsection 11, and make advance interim assessments as reasonable and necessary for organizational and interim operating expenses. Interim assessments must be credited as offsets against any regular assessments due following the close of the fiscal year.

f. Appoint appropriate legal, actuarial, and other committees to provide technical assistance in the operation of the program, policy and contract design, and any other function within the authority of the program.

g. Borrow money to effect the purposes of the program. A note or other indebtedness of the program not in default is a legal investment for carriers and may be carried as an admitted asset.

8. A small employer carrier may reinsure with the program as provided for in this subsection:

a. With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

b. A small employer carrier may reinsure an entire employer group within sixty days after the group's coverage begins under a health benefit plan.

c. A small employer carrier may reinsure an eligible employee or dependent within sixty days after coverage begins with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty days after the coverage begins.

d. (1) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee

or dependent as set by the board. The board shall establish retention levels of reinsuring carriers for reinsurance under sections 1 through 12 and section 16 of this Act at an amount of not less than fifty thousand dollars nor greater than one hundred thousand dollars. A reinsuring carrier's liability under this paragraph may not exceed the maximum limit established by the board in a calendar year for a reinsured individual.

(2) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

e. A reinsuring carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

f. A reinsuring carrier or small employer carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

9. a. The board, as part of the plan of operation, shall establish a method for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The method must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The method must provide for the development of base reinsurance premium rates which must be multiplied by the factors set forth in subdivision b to determine the premium rates for the program. The board shall establish the base reinsurance premium rates, subject to the approval of the commissioner, and shall set the rates at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under sections 1 through 12 and section 16 of this Act.

b. Premiums for the program are:

(1) An entire small employer group may be reinsured for a rate that is not greater than one and one-half times the base reinsurance premium rate for the group established under this section.

(2) An eligible employee or dependent may be reinsured for a rate that is not greater than five times the base reinsurance premium rate for the individual established under this section.

c. The board shall review the method established under subdivision a, periodically, including the system of classification and any rating

factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the method. The changes are subject to the approval of the commissioner.

d. The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

10. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in section 4 of this Act.

11. a. Prior to March first of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

b. Any net loss for the year must be recouped by assessments of small employer carriers.

(1) The board shall establish, as part of the plan of operation, a formula by which to make assessments against small employer carriers. The assessment formula must be based on:

(a) Each small employer carrier's share of the total number of small group enrollees covered in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by small employer carriers; and

(b) Each small employer carrier's share of the total number of small group enrollees covered in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by small employer carriers.

(2) The formula established under this subdivision may not result in any small employer carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of the proportion of the small employer carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by small employer carriers to the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all small employer carriers.

(3) With the approval of the commissioner, the board may change the assessment formula established under this subdivision as appropriate. The board may provide for the shares of the assessment base attributable to total number of small employer group enrollees and to the previous year's total to vary during a transition period.

(4) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for small employer carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

c. (1) Before March first of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(2) If the board determines the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed five percent of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by small employer carriers, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety days following the end of the calendar year in which the losses were incurred. The evaluation must include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement amendments to the plan of operation the commissioner determines necessary to reduce future losses and assessments.

d. If assessments exceed net losses of the program, the excess must be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this subdivision, "future losses" includes reserves for incurred but not reported claims.

e. The board shall determine each small employer carrier's proportion of the assessment annually based on annual statements and other reports determined necessary by the board and filed by the small employer carriers with the board.

f. The plan of operation must provide for the imposition of an interest penalty for late payment of assessments.

g. A small employer carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a small employer carrier if the commissioner determines that payment of the assessment would place the small employer carrier in a financially impaired condition. If all or part of an assessment against a small employer carrier is deferred, the amount deferred must be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The small

employer carrier receiving the deferment remains liable to the program for the amount deferred and may not reinsure any individuals or groups with the program until it pays the assessments.

12. Neither the participation in the program, the establishment of rates, forms, or procedures, nor any other joint or collective action required by sections 1 through 12 and section 16 of this Act may be the basis of any legal action, criminal or civil liability, or penalty against the program or any small employer carriers either jointly or separately.

13. Assessments for the program are exempt from taxes.

14. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall consider the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

15. Nothing in sections 1 through 12 and section 16 of this Act may be construed to require an industrywide trade association plan operating under a master group policy to market, offer, or sell a health benefit plan to employers who are not members of the association. An association which on January 1, 1993, and at least ten years prior to that date, markets, offers, or sells health benefit plans to all members of the association, and does not market, offer, or sell any other individual or group health benefit plan is exempt from sections 1 through 12 and section 16 of this Act. For purposes of sections 1 through 12 and section 16 of this Act, "trade association" means an association with a membership of not less than fifty small employers, each employing more than twenty-five employees serving a single industry, business, or trade that has been actively in existence for at least one year, has a constitution and bylaws or other governing documents, has been formed in good faith for purposes other than for obtaining insurance, and does not condition membership in the association on health status. Notwithstanding this subsection, nothing in this section may be construed to exempt a small employer carrier from sections 1 through 12 and section 16 of this Act.

SECTION 8. Health benefit plan committee.

1. The commissioner of insurance shall appoint a health benefit plan committee composed of representatives of carriers, small employers, employees, health care providers, and producers.

2. The committee shall recommend the form and level of coverage to be made available by a small employer carrier pursuant to section 6 of this Act.

3. The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan each of which contain benefit and cost-sharing levels that are consistent with the basic method

of operation and the benefits of health maintenance organizations, including any restrictions imposed by federal law.

a. The plans recommended by the committee may include cost containment features such as:

(1) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(2) Case management;

(3) Selective contracting with hospitals, physicians, and other health care providers;

(4) Reasonable benefit differentials applicable to providers that do or do not participate in arrangements using restricted network provisions; and

(5) Other managed care provisions.

b. The committee shall submit the health benefit plans described in this subsection to the commissioner for approval within one hundred eighty days after the appointment of the committee.

SECTION 9. Periodic market evaluation. In consultation with members of the committee, the board shall study the effectiveness of sections 1 through 12 and section 16 of this Act at least every three years and report on that study to the commissioner. The report must analyze the effectiveness of sections 1 through 12 and section 16 of this Act in promoting rate stability, product availability, and coverage affordability. The report must address whether carriers and producers are fairly and actively marketing and issuing health benefit plans to small employers in fulfillment of the purposes of sections 1 through 12 and section 16 of this Act. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace and recommendations for market conduct or other regulatory standards or action.

SECTION 10. Waiver of certain state laws. Any law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner, does not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state under sections 1 through 12 and section 16 of this Act.

SECTION 11. Standards to assure fair marketing.

1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

2. a. A small employer carrier or producer may not engage in the following activities, directly or indirectly:

(1) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(2) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

b. Subdivision a does not apply to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. a. A small employer carrier may not enter into any contract, agreement, or arrangement, directly or indirectly, with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

b. Subdivision a does not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided the percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

4. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

5. No small employer carrier may terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

6. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

7. Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

8. A violation of this section by a small employer carrier or a producer is an unfair trade practice under section 26.1-04-03.

9. If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator is subject to this section as if it were a small employer carrier.

SECTION 12. Restoration of terminated coverage. The commissioner may adopt rules to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this Act, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or has not been renewed by the carrier after January 1, 1994. The rules may contain terms for the reissue of coverage as the commissioner determines necessary to provide continuity of coverage to small employers.

SECTION 13. Group health care coverage - Cooperative agreement allowed. The commissioner of insurance shall adopt rules to enable groups to form a cooperative that would allow those groups to purchase group health insurance coverage as one entity.

SECTION 14. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Preventive health care - Copayments. The standard health benefit plan developed under section 8 of this Act must provide coverage for prenatal care visits for a covered person and recommended immunizations and well child visits for a covered person from birth to the age of five years. The plan may impose only a five dollar copayment for each prenatal care visit and a two dollar copayment for each well child visit or immunization visit.

SECTION 15. AMENDMENT. Section 26.1-36-37.1 of the 1991 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36-37.1. Standard health insurance proof of loss form - Claim payment time limits. The commissioner shall prescribe by rule a standard health insurance proof of loss and claim form for use in filing proof of loss and a claim for all health care services. For purposes of this section, "health care service" means any service included in providing an individual with medical, dental, or hospital care or any service incident to providing medical, dental, or hospital care as well as any service provided to prevent, alleviate, care, or heal human illness or injury. After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim or that portion of the claim that is not contested, deny the claim, or make an initial request for additional information. If a claim or a portion of a claim is contested, the insured or the insured's assignee must be notified in writing that the claim is contested and the reasons for the contest. Nothing in this notification precludes the insurer from denying the claim in whole or in part, for other reasons at a later date. Within fifteen business days of the receipt of the information initially requested, the insurer shall pay or deny the claim.

SECTION 16. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Loss ratios - Rules. For all policies providing hospital, surgical, medical, or major medical benefit, an insurance company, a nonprofit health service corporation, a fraternal benefit society, and any other entity providing a plan of health insurance or health benefit subject to state insurance regulation shall return benefits to group policyholders in the aggregate of not less than seventy-five percent of premium received and to individual policyholders in the aggregate of not less than sixty-five percent of premium received. The commissioner shall adopt rules to establish these minimum standards on the basis of incurred

claims experienced and earned premiums for the entire period for which rates are computed to provide coverage in accordance with accepted actuarial principles and practices.

SECTION 17. REPEAL. Chapter 26.1-36.2 of the 1991 Supplement to the North Dakota Century Code is repealed.

Approved April 29, 1993
Filed April 30, 1993

CHAPTER 312

HOUSE BILL NO. 1511
(Representatives Porter, Boucher)
(Senators Evanson, Robinson)
(Approved by the Delayed Bills Committee)

NONPROFIT HEALTH SERVICE CORPORATIONS

AN ACT to amend and reenact subsection 8 of section 26.1-38.1-02 of the North Dakota Century Code, relating to including nonprofit health service corporations in the definition of member insurer under the life and health guaranty association.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[1] **SECTION 1. AMENDMENT.** Subsection 8 of section 26.1-38.1-02 of the North Dakota Century Code is amended and reenacted as follows:

8. "Member insurer" means any insurer, including a nonprofit health service corporation, licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 26.1-38.1-01, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

   a. A health maintenance organization;

   b. A fraternal benefit society;

   c. A mandatory state pooling plan;

   d. A mutual assessment company or any entity that operates on an assessment basis;

   e. A nonprofit health service corporation that is participating in a reinsurance plan that has been approved by the commissioner as an alternative to participation in the state guaranty association;

   f. An insurance exchange; or

~~f.~~ g. Any entity similar to any of the above.

Approved April 28, 1993
Filed April 30, 1993

[1] NOTE: Section 26.1-38.1-02 was also amended by section 106 of Senate Bill No. 2223, chapter 54.

CHAPTER 313

SENATE BILL NO. 2401
(Senator Keller)

AUTOMOBILE INSURANCE BENEFIT PAYEE

AN ACT to create and enact a new section to chapter 26.1-40 of the North Dakota Century Code, relating to payment of automobile insurance benefits to a policyholder's family member.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-40 of the North Dakota Century Code is created and enacted as follows:

Payment of benefits to family members of a policyholder. An automobile insurance policy that provides coverage for bodily injury may not contain any provision limiting payment of benefits or reducing the amount of benefits payable to a person because the person to whom benefits are being paid under that policy is related to the policyholder by blood, marriage, or adoption, or is a foster child, and resides in the same household as the policyholder.

Approved March 24, 1993
Filed March 25, 1993

CHAPTER 314

HOUSE BILL NO. 1415
(Representatives Wald, Rydell, Payne)
(Senators Nalewaja, Thane)

PARTNERSHIP FOR LONG-TERM CARE PROGRAM

AN ACT to provide a partnership for long-term care program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in this Act, unless the context or subject matter otherwise requires:

1. "Commissioner" means the commissioner of insurance.
2. "Department" means the department of human services.
3. "Secretary" means the secretary of the United States department of health and human services.

SECTION 2. Partnership for long-term care program. The commissioner shall coordinate a partnership for long-term care program, by which private insurance and medicaid funds may be combined to finance long-term care. Under the program, an individual may purchase a long-term care insurance policy. The assets of that individual, to the extent those assets do not exceed the amount of long-term care insurance benefits paid as provided in section 3 of this Act, may not be considered by the department as an available asset in a determination of that individual's eligibility for medicaid or of any subsequent claim for recovery by the state of a payment for medical services.

SECTION 3. Long-term care insurance benefit payments - Asset exclusion - Rules. The department shall seek appropriate amendments to its medicaid rules and state plan to allow protection of assets under section 2 of this Act. The protection must be provided, to the extent approved by the secretary, for a purchaser of an approved long-term care insurance policy delivered, issued for delivery, or renewed on or after January 1, 1994. The department shall count insurance benefit payments toward asset exclusion to the extent the payments are for nursing home care or home-based or community-based services, and are for services provided after the individual meets the coverage requirements for long-term care benefits established for this program by the department. The department shall adopt rules to determine the coverage requirements for long-term care benefits.

SECTION 4. Approval of long-term care policies - Rules. The commissioner may approve a long-term care insurance policy only if the policy alerts the purchaser to the availability of consumer information and public education provided under section 5 of this Act, offers the option of home-based and community-based services in lieu of nursing home care, provides, within total benefit limits, payment of necessary covered services, provides for the recordkeeping and an explanation of benefit reports on insurance payments which count toward medicaid asset exclusion, and provides management information and reports necessary to document the extent of

medicaid asset protection offered and to evaluate the partnership for long-term care program. The commissioner may adopt and implement rules relative to coverages provided by the partnership program.

SECTION 5. Outreach program. The commissioner shall establish a program to educate consumers about long-term care, mechanisms for financing long-term care, availability of long-term care insurance, and the asset protection provided by sections 2 and 3 of this Act.

SECTION 6. Funding. The department shall seek federal approval and funds necessary to carry out this Act. The department shall assist the commissioner in preparing the information required by subsections 6, 7, and 8 of section 7 of this Act.

SECTION 7. Report to legislative council and governor. The commissioner shall annually report to the legislative council and to the governor on the progress of the partnership for long-term care program. The report must include:

1. The success in implementing the public and private partnership.
2. The number of long-term care insurance policies approved.
3. The number, age, and financial circumstances of individuals purchasing policies.
4. The number of individuals seeking consumer information services.
5. The extent and type of benefits paid under policies that may count toward medicaid resource protection.
6. Estimates of impact on present and future medicaid expenditures.
7. The cost effectiveness of the program.
8. A determination regarding the appropriateness of continuing the program.

Approved April 7, 1993
Filed April 8, 1993

CHAPTER 315

SENATE BILL NO. 2536
(Senators Thane, Kelly, Krebsbach, Mathern, Mushik, Nalewaja)
(Approved by the Delayed Bills Committee)

LONG-TERM CARE INSURANCE COMPARISON

AN ACT to create and enact a new section to chapter 26.1-45 of the North Dakota Century Code, relating to adoption of long-term care benefits comparison guides by the commissioner of insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-45 of the North Dakota Century Code is created and enacted as follows:

Adoption of long-term care benefits comparison guides by commissioner. The commissioner of insurance shall adopt rules to create a long-term care benefits comparison guide to be presented at the point of sale between the client and agent. The guide must include information regarding nursing home coverage and alternatives to nursing home coverage.

Approved March 30, 1993
Filed April 1, 1993