

**Fifty-sixth Legislative Assembly, State of North Dakota, begun in the
Capitol in the City of Bismarck, on Tuesday, the fifth day of January,
one thousand nine hundred and ninety-nine**

SENATE BILL NO. 2251
(Senator Grindberg)

AN ACT to amend and reenact sections 26.1-38.1-01, 26.1-38.1-02, 26.1-38.1-03, 26.1-38.1-05, 26.1-38.1-06, subsection 5 of section 26.1-38.1-07, subsection 3 of section 26.1-38.1-08, sections 26.1-38.1-09, 26.1-38.1-10, 26.1-38.1-11, 26.1-38.1-12, and 26.1-38.1-16 of the North Dakota Century Code, relating to the life and health insurance guaranty association and the related duties and powers of the insurance commissioner.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-38.1-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-01. Scope.

1. This section provides coverage for the policies and contracts specified in subsection 2:
 - a. To persons, except for nonresident certificate holders under group policies or contracts, who, regardless of where they reside, are the beneficiaries, assignees, or payees of the persons covered under subdivision b; ~~and.~~
 - b. To persons who are owners of or certificate holders under such policies or contracts; ~~or, in the case of other than unallocated annuity contracts, to the persons who are contractholders; and structured settlement annuities, and in each case who~~
 - (1) Are residents; or
 - (2) Are not residents, but only under all of the following conditions:
 - (a) The ~~insurers~~ insurer that issued such policies or contracts ~~are~~ is domiciled in this state;
 - (b) ~~Such insurers never held a license or certificate of authority in the states in which such persons reside~~ The states in which the persons reside have associations similar to the association created under this chapter;
 - (c) ~~Such states have associations similar to the association created by this chapter; and~~
 - (d) ~~Such~~ The persons are not eligible for coverage by such associations an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.
 - c. For any unallocated annuity contract specified in subsection 2, subdivisions a and b of this subsection do not apply, and this chapter, except as provided in subdivisions e and f of this subsection, provides coverage to:
 - (1) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan, the sponsor of which has its principal place of business in this state; and
 - (2) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

- d. For structured settlement annuities specified in subsection 2, subdivisions a and b of this subsection do not apply, and this chapter, except as provided in subdivisions e and f, provides coverage to a person who is a payee under a structured settlement annuity or beneficiary of a payee if the payee is deceased, if the payee:
- (1) Is a resident, regardless of where the contract owner resides; or
 - (2) Is not a resident, and:
 - (a) The contractowner of the structured settlement annuity is a resident, or the contractowner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contractowner resides has an association similar to the association created under this chapter; and
 - (b) Neither the payee or beneficiary nor the contractowner is eligible for coverage by the association of the state in which the payee or contractowner resides.
- e. This chapter does not provide coverage to:
- (1) A person who is a payee or beneficiary of a contractowner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or
 - (2) A person covered under subdivision b, if any coverage is provided by the association of another state to the person.
- f. This chapter provides coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. In determining the application of the provisions of this subdivision in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this chapter must be construed in conjunction with other state laws to result in coverage by only one association.
2. This chapter provides coverage to the persons specified in subsection 1 for direct, nongroup life, health, or annuity, ~~and supplemental policies or contracts, and supplemental contracts to any of these,~~ for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, structured settlement ~~agreements, lottery contracts~~ annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.
3. This chapter does not provide coverage for:
- a. Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner;
 - b. Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;
 - c. Any portion of a policy or contract to the extent that the rate of interest on which it is based:
 - (1) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds

a rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

- (2) On and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;
- d. ~~Any~~ A portion of a policy or contract issued to a plan or program of an employer, association, or similar entity other person to provide life, health, or annuity benefits to its employees or, members, or others, to the extent that such plan or program is self-funded or uninsured including benefits payable by an employer association or similar entity other person under:
- (1) ~~A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended~~ 29 U.S.C. section 1144;
 - (2) A minimum premium group insurance plan;
 - (3) A stop-loss group insurance plan; or
 - (4) An administrative services only contract;
- e. Any portion of a policy or contract to the extent that it provides for dividends or experience rating credits, voting rights, or provides that payment of any fees or allowances be paid to any person, including the policyholder policyowner or contractholder contractowner, in connection with the service to or administration of such policy or contract;
- f. Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;
- g. Any unallocated annuity contract issued to an employee or in connection with a benefit plan protected under the federal pension benefit guaranty corporation regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan; and
- h. Any portion of any unallocated annuity contract which is not issued to, or in connection with, a specific employee, union, or association; or of natural persons benefit plan or a government lottery;
- i. A portion of a policy or contract to the extent that the assessments required by section 26.1-38.1-06 with respect to the policy or contract are preempted by federal or state law;
- j. An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contractowner or policyowner, including:
- (1) Claims based on marketing materials;
 - (2) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;
 - (3) Misrepresentations of or regarding policy benefits;
 - (4) Extracontractual claims; or

- (5) A claim for penalties or consequential or incidental damages; and
- k. A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.
4. The benefits ~~for which that~~ the association may become ~~liable~~ obligated to cover may in no event exceed the lesser of:
- a. The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer;
 - b. With any respect to one life, regardless of the number of policies, or contracts:
 - (1) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;
 - (2) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values; or
 - (3) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
 - c. With respect to each individual participating in a government retirement benefit plan established under section 401(k), 403(b), or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, one hundred thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values; ~~provided, however, that in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one individual under this subdivision and subdivision b; or~~
 - d. ~~With respect to any one contractholder covered by an unallocated annuity contract not included in subdivision b, five million dollars in benefits, irrespective of the number of such contracts held by that contractholder. each payee of a structured settlement annuity or beneficiary, or beneficiaries of the payee if deceased, one hundred thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;~~
 - e. With respect to one contractowner provided coverage under subparagraph d of paragraph 2 of subdivision b of subsection 1; or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subdivision c, five million dollars in benefits, irrespective of the number of contracts with respect to the contractowner or plan sponsor. However, in the case in which one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage must be afforded by the association if the largest interest in the trust or entity owning the contracts or contracts is held by a plan sponsor whose principal place of business is in this state and in no event is the association obligated to cover more than five million dollars in benefits with respect to all these unallocated contracts.
5. However, under subsection 4 in no event shall the association be obligated to cover more than an aggregate of three hundred thousand dollars in benefits with respect to any one life under subdivision b of subsection 4, or with respect to one owner of multiple nongroup policies of life insurance, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or

other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner.

6. The limitations set forth in subsection 4 are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.
7. In performing its obligations to provide coverage under this chapter, the association is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

SECTION 2. AMENDMENT. Section 26.1-38.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-02. Definitions. As used in this chapter:

1. "Account" means either of the two accounts created under section 26.1-38.1-03.
2. "Association" means the North Dakota life and health insurance guaranty association created under section 26.1-38.1-03.
3. "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed under which an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.
4. "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.
5. "Called assessment" or "called" when used in the context of assessments means that a notice was issued by the association to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.
6. "Commissioner" means the insurance commissioner of insurance of this state.
- ~~4.~~ 7. "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 26.1-38.1-01.
- ~~5.~~ 8. "Covered policy" means any policy or contract within the scope of or portion of a policy or contract for which coverage is provided under this chapter under section 26.1-38.1-01.
9. "Extracontractual claims" include claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.
- ~~6.~~ 10. "Impaired insurer" means a member insurer which that, after July 1, 1989, is not an insolvent insurer, and is deemed by the commissioner to be potentially unable to fulfill its contractual obligations or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
- ~~7.~~ 11. "Insolvent insurer" means a member insurer which, after July 1, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

8. 12. "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~~ other person 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
 - g. Any entity similar to any of the above.
9. 13. "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, incorporated, or any successor thereto.
14. "Owner" of a policy or contract and "policyowner" and "contractowner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contractowner, and policyowner do not include persons with a mere beneficial interest in a policy or contract.
40. 15. "Person" means any individual, corporation, limited liability company, partnership, association, governmental entity, or voluntary organization.
16. "Plan sponsor" means:
- a. The employer in the case of a benefit plan established or maintained by a single employer;
 - b. The employee organization in the case of a benefit plan established or maintained by an employee organization; or
 - c. In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.
44. 17. "Premiums" means amounts or considerations, by whatever named called, received in any calendar year on covered policies or contracts less returned premiums, considerations, and deposits ~~returned thereon~~, and less dividends and experience credits ~~thereon~~. "Premiums" do not include any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsections 2 and 3 of section 26.1-38.1-01 and except that assessable premium shall not be reduced on account of subdivision c of subsection 3 of section 26.1-38.1-01, relating to interest limitations, and subsection 3 of section 26.1-38.1-01, relating to limitations with respect to any one individual, any one participant, and any one ~~contractholder; provided that "premiums" do~~ contractowner. "Premiums" do not include ~~any premiums;~~

- a. Premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under section 401(k), 403(b), or 457 of the United States Internal Revenue Code; or
 - b. With respect to multiple nongroup policies of life insurance owned by one owner, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.
18. "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the nature persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the state in which the primary executive and administrative headquarters of the entity is located; in which the principal office of the chief executive officer of the entity is located; in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; from which the management of the overall operations of the entity is directed; and in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty-percent of the participants in the benefit plan are employed in a single state, that state is deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subdivision c of subsection 16 is deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.
19. "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conversation, rehabilitation, or liquidation of the insurer.
42. 20. "Resident" means any person to whom a contractual obligation is owed and who resides in this state ~~at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed~~ on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person must be its principal place of business. Citizens of the United States who are residents of foreign countries, or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created under this chapter, are deemed residents of the state of domicile of the insurer that issued the policies or contracts.
21. "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.
22. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.
43. 23. "Supplemental contract" means any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract ~~proceeds~~.

- ~~14.~~ 24. "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

SECTION 3. AMENDMENT. Section 26.1-38.1-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-03. Creation of the association.

1. There is created a nonprofit legal entity to be known as the North Dakota life and health insurance guaranty association. All member insurers must be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 26.1-38.1-07 and shall exercise its powers through a board of directors established under section 26.1-38.1-04. For purposes of administration and assessment, the association shall maintain two accounts:
 - a. The life insurance and annuity account ~~which~~ that includes the following subaccounts:
 - (1) Life insurance account;
 - (2) Annuity account, which includes annuity contracts owned by a governmental retirement plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities; and
 - (3) Unallocated annuity account ~~which~~ that includes contracts qualified owned by a governmental retirement benefit plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code.
 - b. The health insurance account.
2. The association shall come under the immediate supervision of the commissioner ~~of insurance~~ and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

SECTION 4. AMENDMENT. Section 26.1-38.1-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-05. Powers and duties of the association.

1. If a member insurer is an impaired ~~domestic~~ insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner, ~~and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer:~~
 - a. Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or
 - b. Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision a and assume payment of the contractual obligations of the impaired insurer pending action under subdivision a; ~~or.~~
 - c. ~~Loan money to the impaired insurer.~~
2. ~~a. If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then, subject to the preconditions specified in subdivision b, the association shall, in its discretion, either:~~

- ~~(1) Take any of the actions specified in subsection 1, subject to the conditions therein; or~~
 - ~~(2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.~~
 - b. ~~The association is subject to the requirements of subdivision a only if:~~
 - ~~(1) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:~~
 - ~~(a) The delinquency proceeding shall not be dismissed;~~
 - ~~(b) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and~~
 - ~~(c) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and~~
 - ~~(2) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or~~
 - ~~(3) If the impaired insurer is a foreign or alien insurer,~~
 - ~~(a) It has been prohibited from soliciting or accepting new business in this state;~~
 - ~~(b) Its certificate of authority has been suspended or revoked in this state;~~
 - ~~(c) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.~~
- 3. ~~If a member insurer is an insolvent insurer, the association shall, in its discretion, either shall:~~
 - a. Provide the moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to:
 - (1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or
 - (2) Assure payment of the contractual obligations of the insolvent insurer; ~~and~~
 - (3) ~~Provide such moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or~~
 - b. ~~With respect only to life and health insurance policies, provide~~ Provide ~~benefits and coverage in accordance with subsection 4. the following provisions:~~
- 4. ~~When proceeding under paragraph 2 of subdivision a of subsection 2 or subdivision b of subsection 3, the association shall, with respect to only life and health insurance policies:~~

- a. (1) ~~Assure~~ With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:
 - (+)(a) With respect to group policies and contracts, not later than the earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies and contracts.
 - (-)(b) With respect to ~~individual~~ nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under such policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies or contracts.
- b. (2) Make diligent efforts to provide all known insureds or ~~group policyholders~~ annuitants for nongroup policies and contracts, or group policyowners with respect to group policies and contracts, thirty days' notice of the termination of the benefits provided.
- e. (3) With respect to ~~individual~~ nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, ~~make available~~ substitute coverage on an individual basis in accordance with the provisions of ~~subdivision d~~ paragraph 4, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.
 - d. (a) In providing the substitute coverage required under ~~subdivision e~~ this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy.
 - (+)(b) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.
 - (-)(c) The association may reinsure any alternative or reissued policy.
- e. (4) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types of future issuance without regard to any particular impairment or insolvency.
- f. (5) Alternative policies must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy was last underwritten.

- ~~g.~~ (6) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.
- ~~h.~~ (7) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium must be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the ~~commissioner or by a court of competent jurisdiction~~ domiciliary insurance commissioner and the receivership court.
- ~~i.~~ (8) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the ~~policyholder~~ policyowner, the insured, or the association.
- ~~5.~~ 3. When proceeding under ~~subdivision b of subsection 2 or subsection 3~~ with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision c of subsection 3 of section 26.1-38.1-01.
- ~~6.~~ 4. Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract of substitute coverage terminates the association's obligations under such policy or coverage under this chapter with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.
- ~~7.~~ 5. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contractowners arising after the entry of such order.
- ~~8.~~ 6. The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.
- ~~9.~~ 7. In carrying out its duties under ~~subsections~~ subsection 2 and 3, the association may, ~~subject to approval by the court:~~

 - ~~Impose~~ Subject to approval by a court in this state, impose permanent policy or contract liens in connection with any guarantee assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest.
 - ~~Impose~~ Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral or cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

8. A deposit in this state, held according to law or as required by the commissioner for the benefits of creditors, including policyowners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, under section 26.1-06.1-50, must be paid promptly to the association. The association may retain a portion of any amount received equal to the percentage determined by dividing the aggregate amount of policyowners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policyowners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and retained pursuant to this subsection. Any amount paid to the association less the amount retained by it is treated as a distribution of estate assets pursuant to section 26.1-06.1-43 or similar provision of the state of domicile of the impaired or insolvent insurer.
- 40- 9. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsections ~~subsection 2, 3, and 4~~, the commissioner shall have the powers and duties of the association under this chapter with respect to ~~impaired or~~ insolvent insurers.
- 44- 10. The association may render assistance and advice to the commissioner, upon request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.
- 42- 11. The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over ~~a third party~~ any person or property against whom the association may have rights through subrogation of the insurer's policyholders or otherwise.
- 43- 12. Any person receiving benefits under this chapter must be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contractowner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon such person.
- 44- 13. The subrogation rights of the association under this section have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.
- 45- 14. In addition to subsections ~~43 12~~ and ~~44 13~~, the association shall have all common-law rights of subrogation and other equitable or legal remedy ~~which that~~ would have been available to the impaired or insolvent insurer or ~~holder~~ owner, beneficiary, or payee of a policy or contract with respect to such policy or contract, including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from or payment for the personal injury relating to the annuity.

15. If subsections 12, 13, and 14 are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or portion of the policies covered by the association. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or portion of the policies covered by the association.
16. ~~The~~ In addition to any other rights and powers under this chapter, the association may:
- a. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;
 - b. Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 26.1-38.1-06 and to settle claims or potential claims against it;
 - c. Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;
 - d. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;
 - e. Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims; ~~and~~
 - f. Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the power of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;
 - g. Organize itself as a corporation or in other legal form permitted by the laws of this state;
 - h. Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person promptly shall comply with the request; and
 - i. Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.
17. The association may join an organization of one or more state associations of similar purposes, to further the purposes and administer the powers and duties of the association.
18. At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of the member insurer which accrue on or after this coverage date and which relate to contracts covered in whole or in part by the association under any indemnity reinsurance agreement entered by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer previously and expressly has disaffirmed the reinsurance agreement. The election is effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers. If the association makes an election, subdivisions a through d apply with respect to the agreements selected by the association.

- a. The association is responsible for all unpaid premiums due under the agreements, for periods both before and after the coverage date, and is responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered, in whole or in part, by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.
 - b. The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part, provided that, upon receipt of any of these amounts, the association is obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of the amount received by the association, over the benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event.
 - c. Within thirty days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to every item paid by the member insurer or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. The association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of the aforementioned calculation. If the receiver, rehabilitator, or liquidator received any amounts due the association pursuant to subdivision b, the receiver, rehabilitator, or liquidator shall remit the amounts to the association as promptly as practicable.
 - d. If the association, within sixty days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer may not terminate the reinsurance agreements, to the extent the agreements relate to contracts covered by the association, in whole or in part, and may not set off any unpaid premium due for periods before the coverage date against amounts due the association.
18. If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subsection 17 effective as of the date agreed by the association and the other insurer and regardless of whether the association made the election, provided that:
- a. The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;
 - b. The obligations described in the proviso to subdivision b of subsection 17 no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third-party insurer; and
 - c. Subsection 18 does not apply if the association previously expressly determined in writing that it will not exercise the election referred to in subsection 17.
19. Subsections 17 and 18 supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator remains entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods before the coverage date, subject to applicable setoff provisions.

20. Except as otherwise expressly provided in this section, this section does not alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. This section does not abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This section does not give a policyowner or beneficiary an independent claim for relief against an indemnity reinsurer which is not otherwise set forth in the indemnity reinsurance agreement.
21. The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.
22. If the association arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.
23. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

SECTION 5. AMENDMENT. Section 26.1-38.1-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-06. Assessments.

1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments must be due not less than thirty days after prior written notice to the member insurers and must accrue interest at eighteen percent per annum on and after the due date.
2. There must be two classes of assessment, as follows:
 - a. Class A assessments must be ~~made~~ authorized and called for the purpose of meeting administrative and legal costs and other expenses ~~and examinations conducted under the authority of section 26.1-38.1-09.~~ Class A assessments may be ~~made~~ authorized and called whether or not related to a particular impaired or insolvent insurer.
 - b. Class B assessments must be ~~made~~ authorized and called to the extent necessary to carry out the powers and duties of the association with regard to an impaired or insolvent insurer.
3. The amount of any class A assessment must be determined by the board and may be ~~made~~ authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. ~~A- The total of all non-pro rata assessment assessments may not exceed one hundred fifty dollars per member insurer in any one calendar year.~~
4. The amount of any class B assessment must be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.
5. Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became ~~impaired or insolvent or, as in the case may be of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired,~~ bears to such premiums

received on business in this state for such calendar years by all assessed member insurers.

6. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be ~~made~~ authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection 2 and computation of assessments under this ~~subsection~~ section must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.
7. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral are removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.
8.
 - a. ~~The Subject to subdivision b, the total of all assessments upon authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for each subaccount thereunder may the health account may not in any one calendar year exceed two percent and for the health account may not in any one calendar year exceed two percent of such insurer's average of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this chapter.~~
 - b. If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision a must be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.
 - c. If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon after as permitted under this chapter.
9. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.
10. ~~If a one percent~~ the maximum assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection 4 ~~7~~, the board shall assess ~~at the other~~ subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection 8.
11. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is

necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future ~~losses~~ claims.

12. It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.
13. The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.
14.
 - a. A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and must set forth a brief statement of the grounds for the protest.
 - b. Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.
 - c. Within thirty days after a final decision was made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.
 - d. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.
 - e. If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member insurer.
15. The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall comply promptly with a request.

SECTION 6. AMENDMENT. Subsection 5 of section 26.1-38.1-07 of the North Dakota Century Code is amended and reenacted as follows:

5. The plan of operation may provide that any or all powers and duties of the association, except those under subdivision c of subsection 45 16 of section 26.1-38.1-05 and section 26.1-38.1-06, are delegated to a corporation, limited liability company, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, limited liability company, association, or organization must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, limited liability company, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

SECTION 7. AMENDMENT. Subsection 3 of section 26.1-38.1-08 of the North Dakota Century Code is amended and reenacted as follows:

3. Any final action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the member's receipt of notice of the final action being appealed. ~~If a member company is appealing an assessment, the amount assessed must be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member company.~~ Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state which apply to the action or orders of the commissioner.

SECTION 8. AMENDMENT. Section 26.1-38.1-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-09. Prevention of insolvencies.

1. To aid in the detection and prevention of insurer insolvencies or impairments, it is the duty of the commissioner:
- 4- a. To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:
 - ~~a.~~ (1) Revokes its license;
 - ~~b.~~ (2) Suspends its license; or
 - ~~c.~~ (3) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders ~~policyowners~~ or creditors.
 - (4) Such notice must be mailed to all commissioners within thirty days following the action taken or the date on which such action occurs.
- 2- b. To report to the board of directors when the commissioner has taken any of the actions set forth in ~~subsection 4~~ subdivision a or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors must contain all significant details of the action taken or the report received from another commissioner.
- 3- c. To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company insurer ~~company~~ that such company insurer may be an impaired or insolvent insurer.
- 4- d. To furnish to the board of directors the national association of insurance commissioners insurance regulation information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein must be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.
- 5- 2. The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

6. ~~3.~~ The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations may not be considered public documents.
7. ~~4.~~ ~~It is the duty of the~~ The board of directors, upon majority vote, ~~to~~ may notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.
8. ~~The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination must be paid by the association and the examination report must be treated as are other examination reports. In no event may such examination report be released to the board of directors prior to its release to the public, but this does not preclude the commissioner from complying with subsection 1.~~
- ~~The commissioner shall notify the board of directors when the examination is completed. The request for an examination must be kept on file by the commissioner but it may not be open to public inspection prior to the release of the examination report to the public.~~
9. ~~5.~~ The board of directors ~~may~~, upon majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.
10. ~~The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer and may adopt by reference any report prepared by such other associations.~~

SECTION 9. AMENDMENT. Section 26.1-38.1-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-10. Credits for assessments paid.

1. A member insurer may offset against its premium tax liability to this state an assessment described in ~~subsection 13 of~~ section 26.1-38.1-06 to the extent of twenty percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premiums tax liability for the year it ceases doing business.
2. Any sums which are acquired by refund, pursuant to ~~subsection 11 of~~ section 26.1-38.1-06, from the association by member insurers, and which have theretofore been offset against premium taxes as provided in subsection 1, must be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

SECTION 10. AMENDMENT. Section 26.1-38.1-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-11. Miscellaneous provisions.

1. ~~Nothing in this~~ This chapter ~~may be construed to~~ does not reduce the liability for unpaid assessments of the insured of an impaired or insolvent insurer operating under a plan with assessment liability.
2. Records must be kept of all ~~negotiations and meetings in which the association or its representatives are involved~~ meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 26.1-38.1-05. ~~Records of such negotiations or meetings may be made public only upon~~ The records of the association with respect to an impaired or insolvent insurer may not be disclosed before the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the association to render a report of its activities under section 26.1-38.1-12.
3. For the purpose of carrying out its obligations under this chapter, the association must be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subsections ~~12, 13, and 14, and 15~~ of section 26.1-38.1-05. Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue as covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.
4. As a creditor of the impaired or insolvent insurer as established in subsection 3 and consistent with chapter 26.1-06, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator, within one hundred twenty days of a final determination of insolvency of an insurer by the receivership court, does not apply to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association is entitled to apply to the receivership court for approval of its own proposal to disburse these assets.
5. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, any policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In making such a determination, consideration must be given to the welfare of the ~~policyholders~~ policyowners of the continuing or successor insurer.
5. 6. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 26.1-38.1-05 with respect to such insurer have been fully recovered by the association.
6. 7. If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under ~~such~~ the order has the right to recover on behalf of the insurer, from any affiliate that controlled its capital stock, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections 7, 8, and 9.
7. 8. No such distribution ~~shall be~~ is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

- ~~8.~~ 9. Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared is liable up to the amount of distributions the person would have received if they payment had been ~~paid~~ made immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.
- ~~9.~~ 10. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.
- ~~40.~~ 11. If any person liable under subsection ~~7~~ 8 is insolvent, all its affiliates that controlled it at the time the distribution was paid, are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

SECTION 11. AMENDMENT. Section 26.1-38.1-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-12. Examination of the association - Annual report. The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one hundred twenty days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

SECTION 12. AMENDMENT. Section 26.1-38.1-16 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-16. Prohibited advertisement of Insurance Guaranty Association Act in insurance sales - Notice to ~~policyholders~~ policyowners.

1. No person, including an insurer, agent, or affiliate of an insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by ~~the North Dakota Life and Health Insurance Guaranty Association Act chapter 26.1-38.1~~. Provided, however, that this section does not apply to the North Dakota life and health insurance guaranty association or any other entity ~~which~~ that does not sell or solicit insurance.
2. ~~Within one hundred eighty days after July 1, 1989~~ Before January 1, 1990, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with subsection 3. This document should be submitted to the commissioner for approval. Sixty days after receiving ~~such~~ approval, no insurer may deliver a policy or contract ~~described in subsection 2 of section 26.1-38.1-04~~ to a ~~policyholder or contractholder~~ policy or contractowners unless the summary document is delivered to the ~~policyholder or contractholder~~ policy or contractowner to or at the time of delivery of the policy or contract ~~except if subsection 4 applies~~. The document should also be available upon request by a ~~policyholder~~ policyowner. The distribution, delivery, or contents or interpretation of this document does not mean that either the policy or contract or the ~~holder~~ owner thereof would be covered in the event of the impairment or insolvency of a member insurer. The document must be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the ~~policyholder~~ policyowner, ~~contractholder~~ contractowner, certificate holder, or insured any greater rights than those stated in this chapter.

3. The document prepared under subsection 2 must contain a clear and conspicuous disclaimer on its face. The commissioner shall ~~adopt a rule establishing~~ establish the form and content of the disclaimer. The disclaimer must:
 - a. State the name and address of the life and health insurance guaranty association and insurance department;
 - b. Prominently warn the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner that the North Dakota life and health guaranty association may not cover the policy, or, if coverage is available, it will be subject to substantial limitations and exclusions and be conditioned on continued residence in this state;
 - c. State the types of policies for which guaranty funds will provide coverage;
 - d. State that the insurer and its agents are prohibited by law from using the existence of the North Dakota life and health guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;
 - e. Emphasize that the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner should not rely on coverage under the North Dakota life and health guaranty association when selecting an insurer; and
 - f. Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and
 - g. Provide other information as directed by the commissioner, including sources for information about the financial condition of insurers provided the information is not proprietary and is subject to disclosure under the state's public records law.
4. ~~No insurer or agent may deliver a policy or contract described in subsection 2 of section 26.1-38.1-01 and excluded under subdivision a of subsection 3 of section 26.1-38.1-01 from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policyholder or contractholder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the North Dakota life and health guaranty association. The commissioner shall by rule specify the form and content of the notice. A member insurer shall return evidence of compliance with subsection 2 for so long as the policy or contract for which the notice is given remains in effect.~~

President of the Senate

Speaker of the House

Secretary of the Senate

Chief Clerk of the House

This certifies that the within bill originated in the Senate of the Fifty-sixth Legislative Assembly of North Dakota and is known on the records of that body as Senate Bill No. 2251.

Senate Vote: Yeas 49 Nays 0 Absent 0

House Vote: Yeas 94 Nays 0 Absent 4

Secretary of the Senate

Received by the Governor at _____ M. on _____, 1999.

Approved at _____ M. on _____, 1999.

Governor

Filed in this office this _____ day of _____, 1999,
at _____ o'clock _____ M.

Secretary of State