

CHAPTER 26.1-17 NONPROFIT HEALTH SERVICE CORPORATIONS

26.1-17-01. Definitions.

As used in this chapter, unless the context requires otherwise:

1. "Dental service" means the general and usual service rendered and the care administered by licensed dentists.
2. "Health service" means service performed for and rendered to persons to restore, maintain, and promote personal health, to treat injuries and cure diseases, both physical and mental, by any lawful means, and includes hospital service, medical service, dental service, or optometric service, or any combination of these services. However, health service is limited to those services rendered by physicians, surgeons, practitioners, nurses, hospitals, nursing homes, or any other provider of health service who is licensed or registered under the laws of this state.
3. "Health service contract" means a contract which provides for the furnishing of one or more kinds of health service to a subscriber.
4. "Health service corporation" means a nonprofit corporation organized for the purposes of establishing a health service plan whereby one or more kinds of health service is provided to subscribers under a prepaid health service contract entitling each subscriber to certain specified health services, but does not include a health maintenance organization organized under chapter 26.1-18.1.
5. "Hospital service" includes bed and board, general nursing care, use of the operating room, use of the delivery room, ordinary medications and dressings, and other customary routine care, and nursing home services and health care and related services furnished by vendors of the services, but does not include the practice of medicine.
6. "Medical service" means the general and usual services rendered and care administered by physicians and oral surgeons.
7. "Optometric service" means the general and usual services rendered and care administered by practitioners.
8. "Oral surgeon" means a dentist who has met all of the formal requirements to be certified by the American board of oral surgery.
9. "Practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice one's profession under North Dakota law.

26.1-17-02. Nonprofit health service corporations authorized.

A health service corporation must be organized under this chapter and, to the extent applicable, under chapter 10-33 for the purposes of establishing and putting into effect a health service plan whereby one or more kinds of health service is provided to subscribers under a contract entitling each subscriber to certain specified health service. Any corporation subject to this chapter is not subject to the laws of this state relating to insurance and insurance companies, except as specifically provided in such laws. This chapter applies only to corporations organized pursuant to its provisions, except as specifically provided otherwise.

26.1-17-03. Articles of incorporation and bylaws - Filing.

The articles of incorporation of a health service corporation, and all amendments, are to be filed with the secretary of state. A certified copy of the articles of incorporation and the bylaws, and all amendments, is to be filed with the commissioner.

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 subscriber directors must be made by the existing 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.

26.1-17-05. Authority of corporation writing hospital service contracts.

In addition to any other powers granted by law, a health service corporation writing hospital service contracts may:

1. Enter into contracts for the rendering of hospital service to any of its subscribers with hospitals maintained and operated by the state or any of its political subdivisions, or by any corporation, limited liability company, association, or individual. The hospital service plan operated by the corporation may provide for hospital service and other related health services, excluding the practice of medicine, as advancements in health care and treatment warrant the extension and providing of such services and in case of emergency or expediency. All hospital and related health services provided are subject to the approval of the health service corporation.
2. Make and enter into mutual agreements with hospitals or groups of hospitals, nursing homes, and other vendors and furnishers of health care services and other related facilities, excluding the practice of medicine.
3. Make and enter into mutual agreements with state, federal, or other governmental agencies to provide hospital services, nursing home care, and other related health services, excluding the practice of medicine, including health care services for the needy and other persons.
4. Make and enter into mutual agreements with any other health care corporation or with any state or local government or agency thereof to provide health care administrative services, to act as administrator of any other health care service plan, or to act as a marketing agency or as a fiscal intermediary of any health care plan or of any other health care organization or of any state or local government or agency.
5. Enter into contracts with other corporations, including insurance companies but only with prior approval of the commissioner, or other entities in this state or in other states or possessions of the United States, or of Canada or other foreign countries so that:
 - a. Reciprocity of benefits may be provided to subscribers.
 - 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.

26.1-17-05.1. Authority of corporation writing medical service contracts.

A health service corporation writing medical service contracts may:

1. Enter into contracts with subscribers whereby each subscriber, subscriber member, officer, or employee is entitled to certain specified health services as provided in the subscriber's contract.

2. Enter into contracts with similar corporations within or without the state for the interchange of services to those included in subscription or other similar contracts, and may provide subscription contracts for the substitution of such services in lieu of those therein recited.
3. Enter into contracts with physicians for the rendering of medical service to subscribers in accordance with the terms of the subscriber contract.
4. Enter into contracts with laboratories and vendors of health appliances and prostheses to provide material and services pursuant to contracts with subscribers.

26.1-17-06. Authority of corporation writing optometric service contracts.

A health service corporation writing optometric service contracts may:

1. Enter into contracts with subscribers whereby each subscriber, subscriber member, officer, or employee is entitled to certain specified health services as provided in the subscriber's contract.
2. Enter into contracts with similar corporations within or without the state for the interchange of services to those included in subscription or other similar contracts, and may provide subscription contracts for the substitution of such services in lieu of those therein recited.
3. Enter into contracts with practitioners for the rendering of optometric service to subscribers in accordance with the terms of the subscriber contract.
4. Enter into contracts with optical laboratories to provide material pursuant to contracts with subscribers.

26.1-17-07. Authority of corporation writing certain health service contracts.

A health service corporation writing health service contracts other than hospital service, medical service, and optometric service contracts may:

1. Enter into contracts with subscribers whereby each subscriber, subscriber member, officer, or employee is entitled to certain specified health services as provided in the subscriber's contract.
2. Enter into contracts with similar corporations within or without the state for the interchange of services to those included in subscription or other similar contracts, and may provide subscription contracts for the substitution of such services in lieu of those therein recited.
3. Enter into contracts with health service providers for the rendering of health services to subscribers in accordance with the terms of the subscriber contract.
4. Enter into contracts with laboratories and vendors of health appliances and prostheses to provide material and services pursuant to contracts with subscribers.

26.1-17-08. Corporation not authorized to practice a profession.

This chapter does not authorize a health service corporation to engage in the practice of medicine, dentistry, optometry, or any other profession for which a license or registration is required.

26.1-17-09. Capital - Repayment.

A health service corporation writing hospital service contracts or medical service contracts may not commence business and enter into any contracts with subscribers, nor secure any application therefor, unless the corporation has a contributed surplus of not less than one hundred thousand dollars. A health service corporation writing health service contracts other than hospital service or medical service contracts may not enter into any contracts with any subscribers, nor secure any application therefor, unless the corporation has a contributed surplus of not less than twenty-five thousand dollars. The contributed surplus is repayable when the unassigned earned surplus exceeds the amount required to be initially paid in as contributed surplus, only if the payment does not impair the working capital of the health service corporation.

26.1-17-10. Nonprofit corporation tax exempt - Insurance premium tax - Law governing charitable organizations applicable.

Every nonprofit health service corporation is a charitable and benevolent organization and is exempt from taxation by the state or any political subdivision thereof, except that the tax imposed by section 26.1-03-17 is applicable to a corporation subject to this chapter and the real property of a nonprofit health service corporation is subject to ad valorem taxes and special assessments for special improvements. Except as otherwise provided in this chapter, the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit health service corporations writing health service contracts.

26.1-17-11. Applicability of portion of Nonprofit Corporation Act.

Unless in conflict with this chapter, chapter 10-33 applies to the incorporation, operation, and control of any nonprofit health service corporation.

26.1-17-12. Contract limitations.

1. Except as provided in this section, every physician, oral surgeon, dentist, or practitioner licensed and registered in this state 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. 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.

26.1-17-12.1. Services of registered nurses - Denial of benefits prohibited.

Repealed by S.L. 1995, ch. 246, § 32.

26.1-17-13. Group medical service contracts - Options required.

Repealed by S.L. 1985, ch. 316, § 22.

26.1-17-14. Prisoner's coverage to continue - Conditions.

Repealed by S.L. 1985, ch. 316, § 22.

26.1-17-15. Juvenile's coverage to continue - Conditions.

Repealed by S.L. 1985, ch. 316, § 22.

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.

When 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 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.

26.1-17-17. Coordination of benefit provisions.

Repealed by S.L. 1985, ch. 316, § 22.

26.1-17-18. Health service corporation contracts - Approval by commissioner.

Contracts between a health service corporation and health service providers at all times are subject to the approval of the commissioner. Contracts between health service corporations and subscribers for health service are subject to the applicable provisions of chapter 26.1-36 and are subject to the filing and approval requirements of chapter 26.1-30.

26.1-17-19. Effects of health service contracts.

The issuance of a health service contract by a health service corporation to a subscriber does not create the relationship of hospital and patient, physician and patient, dentist and patient, practitioner and patient, or any other similar relationship between the corporation and the subscriber. The subscriber at all times has the right to select any participating hospital,

physician, oral surgeon, dentist, practitioner, or health service provider, subject to the terms and conditions of the contract. An employee, agent, officer, or member of the board of directors of any such corporation may not influence or attempt to influence any subscriber in the choosing and selecting of the hospital, physician, oral surgeon, dentist, practitioner, or other health service provider who is to care for or treat the subscriber. A civil action arising out of the relationship of hospital and patient, physician and patient, dentist and patient, practitioner and patient, or health service provider and patient may not be maintained against any health service corporation governed by this chapter. A participating practitioner has the right to engage in other practice.

26.1-17-20. Dental and optometric service in accordance with prevailing practice - Emergency service.

All dental or optometric care rendered to a subscriber under the subscriber's contract must be in accordance with the accepted standards of dental or optometric practice prevailing in the community in which the service is rendered.

All service must be rendered by dentists and practitioners duly licensed and registered to practice their profession in this state, except that in case of emergency, and subject to the approval of the board of directors of the health service corporation, the benefits to which a subscriber is entitled under the subscriber's contract may be rendered in another state, provided the services are rendered by a duly licensed dentist or duly licensed practitioner in the other state.

26.1-17-21. Limitations on dental and optometric service contracts.

Every subscriber under a dental or optometric service plan must receive a copy of the contract. The contract must clearly state the care, appliances, materials, and supplies to be provided under the contract and the rate charged the subscriber. Every subscriber must have, at all times, free choice of the dentist or practitioner who is to treat the subscriber, and this right must be prominently printed in the contract. Every optometric service contract must provide that a subscriber has the freedom of choice to have the materials and supplies furnished by any practitioner or optician, the cost for which is to be covered in accordance with the terms of the contract.

26.1-17-22. Health service for needy persons - Payments.

A health service corporation may contract with state, federal, or other governmental agencies, private agencies, corporations, associations, groups, or individuals to provide health services for needy or other persons. A health service corporation may receive from these entities payments covering the cost of all or any part of the contracts.

26.1-17-23. Licensing of sales representatives.

The sales representatives of any health service corporation are subject to the laws pertaining to insurance producers as defined in chapter 26.1-26. The license for a sales representative must be issued on a form prescribed by the commissioner, and the fee for a license or renewal is prescribed in section 26.1-01-07.

26.1-17-24. Unfair insurance practices.

Chapter 26.1-04 applies to health service corporations and contracts with hospitals, doctors of medicine and oral surgeons, dentists, practitioners, health service providers, and subscribers, except to the extent that the commissioner determines that the nature of health service corporations, or of any contracts issued or entered into by those corporations, renders chapter 26.1-04 clearly inappropriate.

26.1-17-25. Rate requirements.

Rates must cover reasonably anticipated claims, cover reasonable costs of operation and overhead expenses, and maintain contingency reserves at a proper level of not less than the

sum of incurred claims and operating and overhead expenses for at least two months, but not more than four months. Rates may not be excessive, inadequate, or unfairly discriminatory.

26.1-17-26. Procedure for submitting rate filings.

1. Each health service corporation shall file with the commissioner every manual of classifications, rates, rating formulas, rating systems, and rules applicable thereto, and any modification of the foregoing which it proposes to use. Each filing must state the proposed effective date thereof and must indicate the character and extent of the coverage contemplated. When a filing is not accompanied by supporting information, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall require the corporation to furnish supporting information, and the waiting period will commence on the date the information is furnished. The information furnished in support of a filing must include the:
 - a. Contract of benefits;
 - b. Current rate structure;
 - c. Claims experience for the most recent period up to three years;
 - d. Claims experience projection for the next eighteen months;
 - e. Letter of opinion from the corporation actuary; and
 - f. Judgment of the corporation and its interpretation of the supporting data.A filing and any supporting information is open to public inspection after the filing becomes effective.
2. The commissioner shall review the filings pursuant to sections 26.1-30-19 through 26.1-30-21 to determine whether they meet the requirements of this chapter.

Upon written application by the corporation, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof.
3. Under the rules the commissioner has adopted, the commissioner may, by written order, suspend or modify the requirements of filing as to any kind of contract for health services, subdivision thereof, or combination thereof, or as to any class of risks, the rates for which cannot practically be filed before they are used. The orders and rules must be made known to the health service corporation affected. The commissioner may make an examination as the commissioner deems advisable to ascertain whether any rates affected by an order meet the standards set forth in section 26.1-17-25.

26.1-17-27. Disapproval of rate filings.

1. If the commissioner finds that a rate filing does not meet the requirements of this chapter, the commissioner shall disapprove the rate filing pursuant to section 26.1-30-21.
2. If at any time subsequent to the applicable waiting period or extension thereof the commissioner finds that a rate filing does not meet the requirements of this chapter, the commissioner shall issue, pursuant to section 26.1-30-21, an order to that effect after a hearing. Copies of the order must be sent to the corporation.
3. Any person or organization aggrieved with respect to any filing which is in effect, except the health service corporation which made the filing, may make written application to the commissioner for a hearing thereon. The application must specify the grounds relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds were established, and that the grounds otherwise justify holding a hearing, the commissioner shall hold, within thirty days after receipt of the application, a hearing upon not less than ten days' written notice to the applicant and to each corporation which made the filing. If after a hearing the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order pursuant to section 26.1-30-21. Copies of this order must be sent to the applicant and to each corporation.

4. A manual of classifications, rules, rating plans, rating formulas, or modifications of any of the foregoing which establish standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of section 26.1-17-26, may not be disapproved if the rates thereby produced meet the requirements of this chapter.

26.1-17-28. Information to be furnished subscribers - Hearings and appeals of subscribers.

Each health service corporation, within a reasonable time after receiving a written request therefor, shall furnish to any subscriber with whom it has a contract and who is affected by a rate made by it, or to the authorized representative of the subscriber, all pertinent information as to the rate.

Each corporation must provide reasonable means whereby any person aggrieved by the application of its rating system, rating formula, or rate may be heard in person or through that person's authorized representative on that person's written request to review the manner in which the rating system, rating formula, or rate has been applied in connection with the contract issued to that person. If the corporation fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if the application has been rejected. Any party affected by the action of a corporation on such request may appeal, within thirty days after written notice of the action, to the commissioner who, after hearing held upon not less than ten days' written notice to the appellant and to the corporation, may affirm or reverse the action.

26.1-17-29. False or misleading information - Penalty.

A subscriber under a health service contract or a health service corporation may not willfully withhold information from, or give false or misleading information to, the commissioner or any statistical agency designated by the commissioner, when the information given or withheld will affect the rates or premiums chargeable under this chapter. Any subscriber or corporation who violates this section is guilty of an infraction.

26.1-17-30. Investment of funds.

The funds of any health service corporation may be invested only in those investments authorized to be made by domestic insurance companies of this state. Investments made prior to July 1, 1983, are subject to the requirements for authorized investments prior to July 1, 1983, and not to the requirements for authorized investments after July 1, 1983.

26.1-17-31. Annual statement.

Every health service corporation 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. The statement must be in the form and must contain the information prescribed by the commissioner.

26.1-17-32. Investigation and examination.

The commissioner, or any deputy or examiner designated by the commissioner, has the right, at all reasonable times, to free access to all books and records of a health service corporation, and may summon and examine, under oath, the officers and employees of the corporation in all matters pertaining to its financial condition. The corporation must bear the expense of any examination of its books and financial condition.

26.1-17-33. Liquidation - Dissolution - Merger - Consolidation.

Any involuntary liquidation and dissolution of a health service corporation is governed by chapter 26.1-07. Any voluntary liquidation and dissolution is governed by chapter 10-33. Any merger or consolidation of a health service corporation is subject to the approval of the commissioner in accordance with the procedures set forth in chapter 26.1-07, but the consolidation or merger must be accomplished under chapter 10-33.

26.1-17-33.1. Nonprofit health service corporation - Conversion to nonprofit mutual insurance company - Application of law.

1. Any nonprofit health service corporation organized under chapter 26.1-17, having admitted assets in excess of all liabilities at least equal to the original surplus required of a mutual insurance company by section 26.1-12-10, without reincorporation, and upon adoption of a resolution by its board of directors, may petition the insurance commissioner for an order to become a nonprofit mutual insurance company subject to chapter 26.1-12. For the purpose of obtaining approval from the insurance commissioner, conversion to a nonprofit mutual insurance company under this section is deemed a consolidation pursuant to chapter 26.1-07 and the procedure described therein must be followed.
2. Upon becoming subject to chapter 26.1-12, the company may continue to provide health care and related services to its present or future members and subscribers by health care contracts and may make provision for the payment of health care services directly to hospitals and other agencies or institutions or persons rendering health care services or related services or may make direct payment to the member or subscriber. The conversion of a nonprofit health service corporation into a mutual insurance company must not impair the rights or obligations or any existing contractual rights of a health care service corporation or its members. Except as provided in this section, the laws that apply to mutual insurance companies, and insurance companies generally, apply to a nonprofit mutual insurance company converted from a nonprofit health service corporation pursuant to this section.
3. The nonprofit corporation laws apply to the operation and control of a nonprofit mutual insurance company converted from a nonprofit health service corporation under this section and supersede any conflicting provisions in title 26.1 unless title 26.1 is more restrictive.
4. The funds of a nonprofit mutual insurance company may be invested in those investments authorized to be made by domestic insurance companies under section 26.1-05-19, as limited by section 26.1-05-18.
5. A nonprofit mutual insurance company may form a wholly owned company for the purpose of administering Medicare claims and engaging in other business activities that do not accept insurance risk. A company established under this subsection may form a joint venture or subsidiary to conduct one or more of the functions the nonprofit mutual insurance company could conduct directly. An officer, a director, or a management employee of the nonprofit mutual insurance company may not directly or indirectly own an interest in a subsidiary.
6. Except as authorized under subsection 12, a nonprofit mutual insurance company may not demutualize. A nonprofit mutual insurance company may not be converted to a for-profit mutual company or to a for-profit stock company.
7. A nonprofit mutual insurance company may avail itself of the additional investment authority under chapter 26.1-10. Upon approval by the commissioner after a showing of good cause by the nonprofit mutual insurance company, aggregate investments in all subsidiaries of the company under subsection 20 of section 26.1-05-19 and under chapter 26.1-10 may exceed an amount equal to twenty-five percent of the company's admitted assets.
8. A conversion of a nonprofit health service corporation to a nonprofit mutual insurance company under this section or the restructuring of a nonprofit mutual insurance company under subsection 12, to the extent that any assets of the nonprofit health service corporation or the restructured nonprofit mutual insurance company and the restructured nonprofit mutual insurance company's nonprofit holding corporation parent formed pursuant to subsection 12 are impressed with a charitable trust immediately before the conversion or restructuring, does not give rise to a breach of the charitable trust or violate any fiduciary duty laws, and does not constitute grounds for disapproval of the petition to convert to a nonprofit mutual insurance company, the articles of incorporation of the company under section 26.1-12-04, or application for restructuring of a nonprofit mutual insurance company under subsection 12. A

conversion or restructuring authorized by this section does not diminish the application of charitable trust or fiduciary duty laws that may apply to the converted or restructured company immediately before the conversion.

9. A nonprofit mutual insurance company may not engage in the practice of medicine, dentistry, optometry, or any other profession for which a license or registration is required.
10. Each nonprofit mutual insurance company and each nonprofit mutual insurance company and its nonprofit holding corporation parent are charitable and benevolent organizations and the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit mutual insurance companies and restructured nonprofit mutual insurance companies and their nonprofit holding corporation parents.
11. Except as authorized under subsection 12, a nonprofit mutual insurance company may not form a mutual insurance holding company.
12. Upon approval of the nonprofit mutual insurance company's board of directors, the approval of the commissioner pursuant to this subsection, and any necessary approval of the nonprofit mutual insurance company's members, a nonprofit mutual insurance company may restructure, while remaining a nonprofit corporation, by forming a nonprofit holding corporation that will be the sole member of the restructured company.
 - a. The restructured company shall retain any additional authority granted to the restructured company as a nonprofit mutual insurance company under this section and the restructured company shall remain subject to subsections 3, 4, 5, 6, 7, 8, 9, and 10, except to the extent inconsistent with this subsection and chapter 10-33.
 - b. The restructured company must be treated as a mutual insurance company subject to the provisions of chapter 26.1-12, except for sections 26.1-12-01, 26.1-12-02, 26.1-12-03, 26.1-12-05, 26.1-12-06, 26.1-12-07, 26.1-12-08, 26.1-12-09, 26.1-12-10, 26.1-12-14, 26.1-12-16, 26.1-12-18, 26.1-12-19, 26.1-12-23, 26.1-12-24, 26.1-12-25, 26.1-12-26, 26.1-12-29, and 26.1-12-30.
 - c. The restructured company may elect to use the term "mutual" in the company's name, marketing materials, and other communications.
 - d. The nonprofit holding corporation is subject to the provisions of sections 26.1-12-06, 26.1-12-07, 26.1-12-14, and 26.1-12-16. After restructuring under this subsection, chapter 26.1-12.1 does not apply to the restructured company or the restructured company's nonprofit holding corporation parent.
 - e. The membership interests of the members of the restructuring company must be converted into membership interests in the nonprofit holding corporation; however, notwithstanding section 26.1-12-14, upon the effective date of the restructuring, such membership interests may be weighted or otherwise adjusted to reflect the number of subscribers covered under a particular policy. Concomitantly with the restructuring, and without complying with sections 26.1-10-05 and 26.1-10-05.1, the restructuring company may transfer or assign the restructuring company's shares, membership units, or other incidents of ownership in one or more of the restructuring company's subsidiaries and affiliates, as well as the restructuring company's workforce, to the nonprofit holding corporation.
 - f. The restructuring company shall submit an application for restructuring, consisting of revised articles and bylaws, the articles and bylaws of the nonprofit holding company, any share or membership interest transfer documents, authorizing resolutions and other materials the restructuring company deems pertinent to the restructuring to the commissioner. The commissioner shall approve the restructuring unless, after a public hearing, the commissioner finds:
 - (1) After the change of control, the domestic insurance company referenced in subsection 1 would not be able to satisfy the requirements for the issuance of a certificate of authority to write the lines of insurance for which the domestic insurance company is presently licensed;

- (2) The effect of the merger or other acquisition of control would be to substantially lessen competition in insurance in this state or tend to create a monopoly in this state;
 - (3) The financial condition of any acquiring party might jeopardize the financial stability of the insurance company or prejudice the interest of the insurance company's policyholders;
 - (4) The acquiring party's plans or proposals to liquidate the insurance company, to sell the insurance company's assets, to consolidate or merge with any person, or to make any other material change in the insurance company's business or corporate structure or management are unfair and unreasonable to policyholders of the company and are not in the public interest;
 - (5) The competence, experience, and integrity of those persons that would control the operation of the insurance company are such that it would not be in the interest of policyholders of the company and of the public to permit the merger or other acquisition of control; or
 - (6) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.
- g. Within thirty days of submission of the application to the commissioner under this subsection, the commissioner shall make written findings, conclusions, and a determination on the application.
13. A merger or consolidation of a nonprofit mutual insurance company that has been restructured under subsection 12, merger or consolidation of the restructured nonprofit mutual insurance company's nonprofit holding corporation parent, acquisition of control of either, or acquisition of another insurer by the restructured company or the restructured company's nonprofit holding corporation parent is subject to the provisions of sections 26.1-10-03 and 26.1-10-03.1 and chapter 26.1-07 which would be applicable to the type of transaction involved.
14. This section does not supersede or impair the rights, powers, or authority of the attorney general or courts of this state established by statute, case law, or common law with respect to charitable or benevolent corporations.

26.1-17-34. Hearing procedure and judicial review.

- 1. Any health service corporation aggrieved by any order or decision of the commissioner made without a hearing, within thirty days after notice of the order to the corporation, may make written request to the commissioner for a hearing thereon. The commissioner shall hear the party within twenty days after receipt of the request and shall give not less than ten days' written notice of the time and place of the hearing. Within fifteen days after the hearing, the commissioner shall affirm, reverse, or modify the previous action specifying the reasons therefor. Pending a hearing and decision thereon, the commissioner may suspend or postpone the effective date of the previous action.
- 2. This chapter does not require the observance at any hearing of formal rules of pleading or evidence.