Sixty-sixth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1116

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to amend and reenact sections 26.1-38.1-01, 26.1-38.1-02, 26.1-38.1-03, 26.1-38.1-04, 26.1-38.1-05, 26.1-38.1-06, 26.1-38.1-08, 26.1-38.1-09, 26.1-38.1-10, 26.1-38.1-11, 26.1-38.1-13, 26.1-38.1-14, and 26.1-38.1-16 of the North Dakota Century Code, relating to the North Dakota life and health insurance guaranty association; to repeal section 26.1-38.1-17 of the North Dakota Century Code, relating to application of laws to an insolvent insurer; and to provide for application.

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~~Coverage and limitations.

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, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subdivision b.
   b. To persons who are owners of or certificate holders or enrollees under such policies or contracts other than unallocated annuity contracts 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 member insurer that issued such policies or contracts is domiciled in this state;

(b) The states in which the persons reside have associations similar to the association created under this chapter; and

(c) The persons are not eligible for coverage by an association in any other state ~~due to the fact that~~because the insurer or the health maintenance organization 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 do not apply, and this chapter, except as provided in subdivisions e and f, 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 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 contract owner of the structured settlement annuity is a resident, or the contract owner 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 contract owner resides has an association similar to the association created under this chapter; and

(b) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

e. This chapter does not provide coverage to:

(1) A person who is a payee or beneficiary of a contract owner 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~~c, if any coverage is provided by the association of another state to the person; or

(3) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in section 589(c)(3)(A) of title 26 of the United States Code, regardless of whether the transaction occurred before or after this federal law became effective.

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, enrollee, 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 policies or contracts of direct, nongroup life insurance, health insurance, which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates, or ~~annuity policies or contracts~~annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and supplemental contracts to any of these 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, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

3. ~~This~~Except for the portion of a policy or contract, including a rider, which provides long-term care or any other health insurance benefits, this chapter does not provide coverage for:
   a. Any portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy owner or contract owner;
   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 the portion of the policy or contract is based or to the extent that the rate of interest, crediting of a rate of interest, or similar factor determined by using an index or other external reference stated in the policy or contract which is employed in calculating returns or changes in value:
      (1) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, 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 prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and
      (2) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;
   d. A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that such plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under:
      (1) A multiple employer welfare arrangement as defined in ~~29 U.S.C. 1144~~section 1144 of title 29 of the United States Code;

(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 payment of any fees or allowances to any person, including the policy owner or contract owner, in connection with the service to or administration of ~~such~~the 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~~the policy or contract in this state;

g. Any unallocated annuity contract issued to 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;

h. Any portion of any unallocated annuity contract which is not issued to, or in connection with, a specific employee, union, or association 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 or otherwise not permitted 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 member insurer to the enrollee, certificate holder, contract owner or policy owner, including:

(1) Claims based on marketing materials;

(2) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(3) Misrepresentations of or regarding policy or contract benefits;

(4) Extracontractual claims; or

(5) A claim for penalties or consequential or incidental damages;

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;

l. A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which has not been credited to the policy or contract, or as to which the policy owner's or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or changes in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and is not subject to forfeiture; ~~and~~

m. A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to part C or part D of subchapter XVIII~~,~~ of chapter 7 of title 42 of the United States Code ~~(~~, commonly known as Medicare part C and part D~~)~~, or subchapter XIX of chapter 7 of title 42 of the United States Code; commonly known as Medicaid, or any regulations issued pursuant thereto; and

n. Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transactions, as defined in section 5891(c)(3)(A) of title 26 of the United States Code, regardless of whether the transaction occurred before or after this federal law became effective.

4. The benefits that the association may become obligated to cover may in no event exceed the lesser of:

a. The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

b. (1) With any respect to one life, regardless of the number of policies, or contracts:

(a) 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;

(b) ~~In~~For health insurance benefits:

[1] One hundred thousand dollars for coverages not defined as disability income insurance or ~~basic hospital, medical, and surgical insurance or major medical insurance~~health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values.

[2] Three hundred thousand dollars for disability income insurance, and three hundred thousand dollars for long-term care insurance.

[3] Five hundred thousand dollars for ~~basic hospital, medical, and surgical insurance or major medical insurance~~health benefit plans.

(c) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(2) 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, two hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(3) With respect to each payee of a structured settlement annuity or beneficiary, or beneficiaries of the payee if deceased, two hundred fifty thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(4) However, in no event shall the association be obligated to cover more than:

(a) An aggregate of three hundred thousand dollars in benefits with respect to any one life under paragraphs 1, 2, and 3 of subdivision b except with respect to the benefits for ~~basic hospital, medical, and surgical insurance and major medical insurance~~health benefit plans under subparagraph b of paragraph 1 of subdivision b, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or

(b) With respect to one owner of multiple nongroup policies of life insurance, 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.

(5) With respect to either one contract owner provided coverage under ~~subparagraph c of~~ paragraph 2 of subdivision ~~b~~c of subsection 1; or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in paragraph 2 of subdivision b, five million dollars in benefits, irrespective of the number of contracts with respect to the contract owner 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 contract 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.

(6) The limitations set forth in this subsection 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.

5. In performing its obligations to provide coverage under this chapter, the association is not required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, 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.

6. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract must be considered the same type of benefits as the related base life insurance policy or annuity 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 time frame 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 this state.

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.

8. "Covered contract" or "covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided under this chapter.

9. "Extracontractual claims" include claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney's fees and costs.

10. "Health benefit plan" means any hospital or medical expense policy or certificate, any health maintenance organization subscriber contract, or any other similar health contract. The term does not include:

   a. Accident only insurance;

   b. Credit insurance;

   c. Dental only insurance;

   d. Vision only insurance;

   e. Medicare supplement insurance;

   f. Benefits for long-term care, home health care, community-based care, or any combination of these benefits;

   g. Disability income insurance;

   h. Coverage for onsite medical clinics; or

   i. Specified disease, hospital confinement indemnity, or limited health insurance, if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

11. "Impaired insurer" means a member insurer that, after July 1, 1989, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

~~11.~~12. "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.

~~12.~~13. "Member insurer" means any insurer~~, including a nonprofit health service corporation, or health maintenance organization~~ licensed or which holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under section 26.1-38.1-01~~, and~~. The term

includes any insurer or health maintenance organization 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.~~b. A mandatory state pooling plan;

~~d.~~c. A mutual assessment company or 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.~~d. An insurance exchange;

~~g.~~e. An organization that has a certificate or license limited to the issuance of charitable gift annuities under sections 26.1-34.1-01 through 26.1-34.1-07; or

~~h.~~f. Any entity similar to any of the above.

~~13.~~14. "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, incorporated, or any successor thereto.

~~14.~~15. "Owner" of a policy or contract and "policyholder", "policy owner" and "contract owner" 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 member insurer. The terms owner, contract owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

~~15.~~16. "Person" means any individual, corporation, limited liability company, partnership, association, governmental entity, or voluntary organization.

~~16.~~17. "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.

~~17.~~18. "Premiums" means amounts or considerations, by whatever name called, received ~~in any calendar year~~ on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits. "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 policy or contract owner. "Premiums" do not include:

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 policy or contract owner 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.~~19. a. "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural 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 following factors: the state in which the primary executive and administrative headquarters of the entity is located; the state in which the principal office of the chief executive officer of the entity is located; the state in which the board of directors or similar governing person or

persons of the entity conducts the majority of its meetings; the state 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; the state 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.

b. The principal place of business of a plan sponsor of a benefit plan described in subdivision c of subsection ~~16~~17 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.~~20. "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

~~20.~~21. "Resident" means any person to whom a contractual obligation is owed and who resides in this state 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 member insurer that issued the policies or contracts.

~~21.~~22. "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

~~22.~~23. "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.

~~23.~~24. "Supplemental contract" means any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

~~24.~~25. "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 or a health maintenance organization business 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 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 that excludes contracts 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 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 26.1-38.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-04. Board of directors.

1. The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The insurer members of the board must be selected by member insurers, subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term by a majority vote of the remaining board members, for member insurers, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights of the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.
2. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.
3. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the association for their services.

SECTION 5. 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 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:

a. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, 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 assure payment of the contractual obligations of the impaired insurer pending action under subdivision a.

2. If a member insurer is an insolvent insurer, the association, in its discretion, ~~either~~ shall:

a. ~~Provide the moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to:~~

~~(1)~~ Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; ~~or~~

~~(2)~~b. Assure payment of the contractual obligations of the insolvent insurer; ~~or~~

~~b.~~c. Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

d. Provide benefits and coverage in accordance with the following provisions:

(1) With respect to ~~life and health insurance policies and annuities,~~policies and contracts, 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~~those 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~~the policies and contracts.

(b) With respect to 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~~the policies or contracts.

(2) Make diligent efforts to provide all known insureds, enrollees or annuitants for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination pursuant to paragraph 1 of the benefits provided.

(3) With respect to nongroup ~~life and health insurance~~ policies and ~~annuities~~contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or ~~formerly an~~ annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph 4, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

(a) In providing the substitute coverage required under this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner.

(b) Alternative or reissued policies or contracts 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 or contract.

(c) The association may reinsure any alternative or reissued policy or contract.

(4) Alternative policies or contracts 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 or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(5) Alternative policies or contracts 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 or contract was last underwritten.

(6) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(7) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium must be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the ~~domiciliary insurance~~ commissioner ~~and the receivership court~~.

(8) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date ~~such~~the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association.

3. When proceeding under subsection 2 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.

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~~for substitute coverage terminates the association's obligations under ~~such~~the policy, contract, or coverage under this chapter with respect to ~~such~~the policy, contract, 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.
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~~. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding the premium collected by the association. The association is liable for unearned premiums due to policy or contract owners arising after the entry of ~~such~~the order.
6. The protection provided by this chapter does not apply when 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.
7. In carrying out its duties under subsection 2, the association may:
   a. 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.
   b. 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 policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~a member 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 policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association ~~and~~, less the amount retained pursuant to this subsection. Any amount paid to the association ~~less the amount~~and 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.

9. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection 2, the commissioner shall have the powers and duties of the association under this chapter with respect to insolvent insurers.

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.

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, reissuing, 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 any person or property against whom the association may have rights through subrogation or otherwise.

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 policies, contracts, or coverages. The association may require an assignment to it of such rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon such person.

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.

14. In addition to subsections 12 and 13, the association shall have all common-law rights of subrogation and other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, 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 or payment for the personal injury, except any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code.

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 contracts or portion of the policies or contracts 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 contracts or portion of the policies or contracts covered by the association.

16. 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 and any notes or other evidences of indebtedness of the association not in default shall be legal investments for domestic member 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;

f. Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the ~~power~~powers of a domestic life ~~or~~insurer, health insurer, or health maintenance organization, 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. Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which the association provides coverage under this chapter; and

~~i.~~j. 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.

19. 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 18 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 18 no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third-party insurer; and

c. This subsection does not apply if the association previously expressly determined in writing that it will not exercise the election referred to in subsection 18.

20. Subsections 18 and 19 supersede the provisions of any law of this state or of any affected reinsurance ~~agreement~~contract 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, rehabilitator, or liquidator, 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.

21. 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 policy owner, contract owner, enrollee, certificate holder, or beneficiary an independent claim for relief against an indemnity reinsurer which is not otherwise set forth in the indemnity reinsurance agreement.

22. 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.

23. 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.

24. Burleigh County is the venue in a course of action against the association arising under this chapter. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

25. ~~Subject to approval of the receivership court, the~~The association, in carrying out association duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections ~~2~~1 and ~~3~~2, may issue substitute coverage for a policy or contract that provides a rate of interest, crediting of a rate of interest, or similar factor determined by using an index or other external reference stated in the policy or contract which is employed in calculating returns or changes in value by issuing an alternative policy or contract if:

a. Instead of the index or other external reference provided for in the ~~replaced~~original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or different method for calculating interest or changes in value;

b. There is no requirement for evidence of insurability, a waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

c. The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

SECTION 6. 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 authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

b. Class B assessments must be authorized and called to the extent necessary to carry out the powers and duties of the association under section 26.1-38.1-05 with regard to an impaired or insolvent insurer.

3. The amount of any class A assessment must be determined at the discretion of the board of directors and must be authorized and called on a non-pro rata basis.

4. The amount of any class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes ~~among~~between the accounts and among the subaccounts of the life insurance and annuity account, 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. The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

6. 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 member insurer became insolvent or, in the case 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 member insurer became impaired, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

~~6.~~7. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to

implement the purposes of this chapter. Classification of assessments under subsection 2 and computation of assessments under this 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.~~8. 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.~~9. a. Subject to subdivision b, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in any one calendar year exceed two percent 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 member insurer became an impaired or insolvent insurer.

b. If two or more assessments are authorized in one calendar year with respect to member 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.~~10. 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.~~11. If 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 ~~7~~4, the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection ~~8~~9.

~~11.~~12. 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 member 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 claims.

~~12.~~13. It is proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

~~13.~~14. The association shall issue to each member 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 member 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.~~15. 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. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

~~15.~~16. 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 7. AMENDMENT. Section 26.1-38.1-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-08. Duties and powers of the commissioner.

In addition to the duties and powers enumerated elsewhere in this chapter:

1. The commissioner shall:

a. Upon request of the board of directors, provide the association with a statement of premiums in this and any other appropriate states for each member insurer;

b. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer constitutes notice to its shareholders, if any; and the failure of the impaired insurer to promptly comply with such demand does not excuse the association from the performance of its powers and duties under this chapter; and

c. In any liquidation or rehabilitation proceedings involving a domestic insurer, be appointed as the liquidator or rehabilitator.

2. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact ~~insurance~~business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture may be less than one hundred dollars per month.

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. 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.

4. The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify any interested persons of the effect of this chapter.

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 member insurer insolvencies or impairments, it is the duty of the commissioner:

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:

(1) Revokes its license;

(2) Suspends its license; or

(3) Makes any formal order that ~~such company~~the member insurer 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 policy owners, contract owners, certificate holders, 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.

b. To report to the board of directors when the commissioner has taken any of the actions set forth in 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.

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 insurer that such insurer may be an impaired or insolvent insurer.

d. To furnish to the board of directors the national association of insurance commissioners insurance ~~regulation~~regulatory 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.

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~~of insurers or health maintenance organizations seeking admission to transact ~~insurance~~ business in this state.

3. The board of directors, upon majority vote, may 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~~insurer or health maintenance organization seeking to do ~~an insurance~~ business in this state. Such reports and recommendations may not be considered public documents.
4. The board of directors, upon majority vote, may notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.
5. The board of directors, upon majority vote, may make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

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 - Tax offsets.

1. A member insurer may offset against its premium tax liability to this state an assessment described in 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~~premium tax liability for the year it ceases doing business.
2. A member insurer that is exempt from taxes referenced in subsection 1 may recoup that member insurer's assessments by a surcharge on that member insurer's premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner. Amounts recouped may not be considered premiums for any other purpose, including the computation of gross premium tax, the medical loss ratio, or agent commission. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount must be applied to reduce future assessments in the appropriate account.
3. Any sums ~~which~~that are acquired by refund, pursuant to 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~~the member 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. This chapter 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 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. 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, except upon the termination of the impairment or solvency of the member 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 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 or contracts, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans 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~~a member 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~~contract owners, certificate holders, enrollees, and policy owners 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 policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

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~~the member insurer have been fully recovered by the association.

7. a. If an order for liquidation or rehabilitation of ~~an~~a member insurer domiciled in this state has been entered, the receiver appointed under the order has the right to recover on behalf of the member insurer, from any affiliate that controlled its capital stock, the amount of distributions, other than stock dividends paid by the member 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 subdivisions b, c, and d.

   b. No such distribution is recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

   c. Any person who was an affiliate that controlled the member 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 member insurer at

the time the distributions were declared is liable up to the amount of distributions the person would have received if payment had been made immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

d. 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.

e. If any person liable under subdivision c 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 26.1-38.1-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-13. Tax exemptions.

The association is exempt from payment of all fees and all taxes levied by this state ~~on~~or any of its subdivisions, except taxes levied on real property.

SECTION 12. AMENDMENT. Section 26.1-38.1-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-38.1-14. Immunity.

There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. ~~Such~~This immunity extends to the participation of any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

SECTION 13. 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 policy owners.

1. No person, including ~~an~~a member insurer, insurance producer, or affiliate of ~~an~~a member 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 or other coverage covered by chapter 26.1-38.1. ~~Provided, however, that~~However, this section does not apply to the North Dakota life and health insurance guaranty association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

2. 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 approval, no member insurer may deliver a policy or contract to a policy ~~or~~owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy ~~or~~owner, contract owner ~~to or~~, certificate holder, or enrollee at the time of delivery of the policy or contract. The document should also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document does not mean that either the policy or contract or the policy owner ~~thereof would be~~, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, 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 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 policy owner ~~or,~~ contract owner, certificate holder, or enrollee that the North Dakota life and health insurance guaranty association may not cover the policy or contract, 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 or contracts for which guaranty funds will provide coverage;

d. State that the member insurer and its insurance producers are prohibited by law from using the existence of the North Dakota life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

e. Emphasize that the policy owner ~~or,~~ contract owner, certificate holder, or enrollee should not rely on coverage under the North Dakota life and health insurance guaranty association when selecting an insurer or health maintenance organization coverage;

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. A member insurer shall retain evidence of compliance with subsection 2 for so long as the policy or contract for which the notice is given remains in effect.

SECTION 14. REPEAL. Section 26.1-38.1-17 of the North Dakota Century Code is repealed.

SECTION 15. APPLICATION. This Act applies to an insolvent insurer that is placed under an order of liquidation with a finding of insolvency after July 31, 2019.