INSURANCE

CHAPTER 276

SENATE BILL NO. 2162

(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE LAW CHANGES

AN ACT to create and enact a new subsection to section 26.1-22.1-06 of the North Dakota Century Code, relating to boiler inspection; and to amend and reenact subsection 10 of section 26.1-01-07, sections 26.1-01-07.5, 26.1-22.1-09, 26.1-22.1-13, 26.1-30-20, subsection 3 of section 26.1-31.2-02, subsection 5 of section 26.1-34-01, subsection 1 of section 26.1-36-05, subsection 27 of section 26.1-36.3-01, subsection 1 of section 26.1-36.3-07, and subdivision g of subsection 3 of section 26.1-38.1-01 of the North Dakota Century Code, relating to fees chargeable by the commissioner of insurance, fire district maps, boiler inspection, policy withdrawal, reinsurance, annuities, group health policies, the small employer health reinsurance program, and the life and health insurance guaranty association.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 10 of section 26.1-01-07 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

10. For ~~each~~ filing the abstract of the annual statement of an insurance company for publication, ~~ten~~ thirty dollars.

SECTION 2. AMENDMENT. Section 26.1-01-07.5 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-01-07.5. Fire district maps - Insurance applications to show fire district in which property is located - Penalty. Before December first of each year, the commissioner of insurance shall publish maps of the fire districts of the state for use by insurers under this section for the following calendar year. The state firemen's association and the state fire marshal shall assist the commissioner of insurance in preparing the maps. After December 31, 1993, no insurer may issue or renew a policy for fire, allied lines, ~~multiple peril crop,~~ homeowner's multiple peril, farmowner's multiple peril, commercial multiple peril, or crop hail insurance coverage for property in this state unless the application identifies each fire district in which the insured property is located. The application must identify the property and insured value of the property located within each fire district if the policy provides coverage for property that is not all within a single district. For purposes of this section, "fire district" means rural fire protection district, city, or area served by a certified rural fire department. An insurer that is found by the commissioner to be in violation of this section is subject to a penalty of one hundred dollars for each such violation to be deposited in the insurance tax distribution fund. The commissioner of insurance may adopt rules necessary for administration of this

section, including rules governing preparation, charges for, and use of maps under this section.

SECTION 3. A new subsection to section 26.1-22.1-06 of the 1993 Supplement to the North Dakota Century Code is created and enacted as follows:

Any electric boiler used as an integral part of an espresso coffee machine, provided that the boiler does not exceed one and one-half cubic feet [.0566 cubic meter] in water capacity, does not exceed fifty pounds per square inch [22.68 kilograms per square centimeter] pressure, and is constructed, approved, or certified to the American society of mechanical engineers code or to other national or international standards.

SECTION 4. AMENDMENT. Section 26.1-22.1-09 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-22.1-09. Inspection fees. Upon completion of inspection, the owner or user of a boiler inspected by the chief boiler inspector shall pay to the commissioner fees or a combination of fees which must be determined ~~annually~~ by the commissioner. The commissioner ~~may~~ must determine and may annually adjust a fee scale for the internal ~~inspection~~ inspections of power boilers, internal inspections of low pressure heating boilers, external inspections of all boilers, and inspection of boilers used exclusively for exhibition purposes.

Not more than one hundred dollars may be charged or collected for ~~the~~ any one inspection of a boiler ~~in a year~~ except for special inspections made upon request. Not more than seventy-five dollars may be charged or collected for ~~an~~ any one inspection of a steam traction engine ~~in a year~~ except for special inspections made upon request. All other inspections made by the chief boiler inspector, including shop inspections and reviews and special inspections when requested by the owner or user of a boiler, must be charged at a rate not to exceed ~~one~~ two hundred eighty-five dollars per day or one hundred fifty dollars per half day of four hours or less, plus payment for mileage, meals, and hotel expenses as allowed by sections 44-08-04 and 54-06-09. The annual fee for the issuance of a reciprocal commission card for a special inspector is twenty dollars and the annual fee for the issuance of a welder-qualified card is ten dollars.

SECTION 5. AMENDMENT. Section 26.1-22.1-13 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-22.1-13. Disposition of funds. All funds collected and received under this chapter must be paid to the state treasurer and deposited in the state fire and tornado fund to be used to defray the costs of boiler inspections. ~~The commissioner shall not issue a certificate of inspection until all inspection fees have been paid in accordance with section 26.1-22.1-09.~~

SECTION 6. AMENDMENT. Section 26.1-30-20 of the North Dakota Century Code is amended and reenacted as follows:

26.1-30-20. Procedure for ~~approval, disapproval, and withdrawal of approval by~~ use of policy forms filed with commissioner. No insurance policy, certificate, contract, agreement, or rate schedule, except as is otherwise provided, may be issued, nor may any application, rider, or endorsement be used in connection therewith until the expiration of sixty days after it has been filed unless the commissioner gives written approval. The commissioner may extend the sixty-day

period for an additional period not to exceed fifteen days if the commissioner gives written notice within the sixty-day period to the insurer which made the filing that the commissioner needs the additional time for the consideration of the filing.

SECTION 7. AMENDMENT. Subsection 3 of section 26.1-31.2-02 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

3. Clean, irrevocable, and unconditional letters of credit; ~~as defined in subsection 1 of section 26.1-31.2-03,~~ issued or confirmed by a qualified United States institution, as defined in subsection 1 of section 26.1-31.2-03, no later than December thirty-first in respect of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs.

SECTION 8. AMENDMENT. Subsection 5 of section 26.1-34-01 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

5. A statement that when an annuity contract becomes a claim by ~~the~~ reason of death ~~of the annuitant~~, settlement:

   a. If payable in one sum, must be made upon due proof of death, or not later than two months after receipt of the proof, and must include reasonable interest accrued from the date of death; or

   b. If made under a settlement option other than subdivision a, must include reasonable interest accrued from date of death until such option is made according to the provisions of the contract.

   As used in this subsection, the term "reasonable interest" means the same rate of interest as paid on death proceeds left on deposit with the insurer.

[153] **SECTION 9. AMENDMENT.** Subsection 1 of section 26.1-36-05 of the North Dakota Century Code is amended and reenacted as follows:

1. A provision that the policyholder or contractholder is entitled to a grace period of ~~fifteen days for monthly premiums and~~ thirty-one days ~~for all others~~ for the payment of any premium due except the first, during which the policy or contract continues in force, unless the policyholder or contractholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy or contract. The policy or contract may provide that

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[153] Section 26.1-36-05 was also amended by section 21 of House Bill No. 1050, chapter 246.

the policyholder or contractholder is liable to the insurer for the payment of a pro rata premium for the time the policy or contract was in force during the grace period.

[154] **SECTION 10. AMENDMENT.** Subsection 27 of section 26.1-36.3-01 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

27. "Small employer" means any person that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least three, but no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, must be considered one employer.

SECTION 11. AMENDMENT. Subsection 1 of section 26.1-36.3-07 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. A nonprofit entity known as the North Dakota small employer health reinsurance program, an instrumentality of the state, is created.

SECTION 12. AMENDMENT. Subdivision g of subsection 3 of section 26.1-38.1-01 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

g. Any unallocated annuity contract issued ~~by~~ to an employee benefit plan protected under the federal pension benefit guaranty corporation; and

Approved March 6, 1995
Filed March 6, 1995

[154] Section 26.1-36.3-01 was also amended by sections 26 and 27 of House Bill No. 1050, chapter 246.

CHAPTER 277

SENATE BILL NO. 2160

(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

INSURANCE COMPANY APPOINTMENT FEES

AN ACT to amend and reenact subsection 24 of section 26.1-01-07 of the North Dakota Century Code, relating to insurance company appointment fees; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 24 of section 26.1-01-07 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

24. For each insurance company appointment and renewal of an appointment of an insurance agent or limited insurance representative, ~~ten~~ fifteen dollars.

SECTION 2. EXPIRATION DATE. This Act is effective through July 31, 1997, and after that date is ineffective.

Approved March 21, 1995
Filed March 23, 1995

CHAPTER 278

SENATE BILL NO. 2178

(Appropriations Committee)
(At the request of the Office of Management and Budget)

INSURANCE REGULATORY TRUST FUND TRANSFER

AN ACT to amend and reenact subsection 3 of section 26.1-01-07.1 of the North Dakota Century Code, relating to transfer of the cash balance in the insurance regulatory trust fund to the general fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-01-07.1 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

3. ~~Any cash balance in the insurance regulatory trust fund after all current biennium expenditures are met must be carried forward in the insurance regulatory trust fund for the next succeeding biennium, except when the balance at the end of the biennium exceeds one million five hundred thousand dollars, any excess will be transferred to the general fund in the state treasury.~~ Except as provided in section 2 of this Act, at the end of each fiscal year, the state treasurer shall transfer, after all fiscal year expenses have been paid, any cash balance remaining in the insurance regulatory trust fund that exceeds one million five hundred thousand dollars to the general fund.

SECTION 2. EXEMPTION. The state treasurer may not include revenue generated by the insurance company appointment or renewal fee increase provided for in Senate Bill No. 2160, as approved by the fifty-fourth legislative assembly, and associated expenditures in calculating transfers from the insurance regulatory trust fund to the general fund pursuant to subsection 3 of section 26.1-01-07.1 for the biennium beginning July 1, 1995, and ending June 30, 1997.

Approved March 7, 1995
Filed March 7, 1995

CHAPTER 279

HOUSE BILL NO. 1173

(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

RISK-BASED CAPITAL FOR INSURERS

AN ACT to create and enact chapters 26.1-03.1 and 26.1-10.1 of the North Dakota Century Code, relating to risk-based capital for insurers and disclosure of material transactions; and to amend and reenact section 26.1-03-11.3 of the North Dakota Century Code, relating to confidentiality and sharing of certain information.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-11.3 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-11.3. Confidentiality. ~~All financial analysis ratios and examination synopsis concerning insurance companies that are submitted to the department by the national association of insurance commissioners' insurance regulatory information system are confidential, may not be disclosed by the department, and are exempt from section 44-04-18.~~ The commissioner shall maintain, as confidential, any confidential documents or information received from the national association of insurance commissioners or state or federal regulatory or law enforcement officials of other states or jurisdictions. The information may not be disclosed by the department and is exempt from section 44-04-18. The commissioner may share information that is confidential under the laws of this state with the national association of insurance commissioners and with state or federal regulatory or law enforcement officials from other states or jurisdictions providing that the officials are required, under their law, to maintain its confidentiality.

SECTION 2. Chapter 26.1-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-03.1-01. Definitions. As used in this chapter:

1. "Adjusted risk-based capital report" means a risk-based capital report that has been adjusted by the commissioner in accordance with subsection 3 of section 26.1-03.1-02.

2. "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

3. "Domestic insurer" means any insurance company domiciled in this state, except a county mutual insurance company.

4. "Foreign insurer" means any insurance company that is licensed to do business in this state under chapter 26.1-11 but is not domiciled in this state.

5. "Life or health insurer" means any licensed life or health insurance company or a licensed property and casualty insurer writing only accident and health insurance.

6. "Negative trend" means, with respect to a life or health insurer, negative trend over a period of time, as determined in accordance with the trend test calculation included in the risk-based capital instructions.

7. "Risk-based capital instructions" means the risk-based report, including risk-based capital instructions adopted by the national association of insurance commissioners, as such risk-based capital instructions may be amended by the national association of insurance commissioners from time to time in accordance with the procedures adopted by the national association of insurance commissioners.

8. "Risk-based capital level" means an insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital and:

   a. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

   b. "Company action level risk-based capital" means, with respect to any insurer, the product of two and its authorized control level risk-based capital.

   c. "Mandatory control level risk-based capital" means the product of seventy hundredths and the authorized control level risk-based capital.

   d. "Regulatory action level risk-based capital" means the product of one and one-half and its authorized control level risk-based capital.

9. "Risk-based capital plan" means a comprehensive financial plan containing the elements specified in subsection 2 of section 26.1-03.1-03. If the commissioner rejects the risk-based capital plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called the "revised risk-based capital plan".

10. "Risk-based capital report" means the report required in section 26.1-03.1-02.

11. "Total adjusted capital" means the sum of:

   a. An insurer's statutory capital and surplus as determined in accordance with statutory accounting applicable to the annual statements required to be filed under section 26.1-03-07; and

   b. Such other items, if any, as the risk-based capital instructions may provide.

26.1-03.1-02. Risk-based capital reports.

1. On or prior to each March first, every domestic insurer shall prepare and submit to the commissioner a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing any information required by the risk-based capital instructions. In addition, every domestic insurer shall file its risk-based capital report:

   a. With the national association of insurance commissioners in accordance with the risk-based capital instructions; and

   b. With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

      (1) Fifteen days from the receipt of notice to file its risk-based capital report with that state; or

      (2) The filing date.

2. A life and health insurer's risk-based capital must be determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take into account, and may adjust for the covariance between:

   a. The risk with respect to the insurer's assets;

   b. The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

   c. The interest rate risk with respect to the insurer's business; and

   d. All other business risks and any other relevant risks as are set forth in the risk-based capital instructions;

   determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

3. A property and casualty insurer's risk-based capital must be determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take into account, and may adjust for the covariance between:

   a. Asset risk;

   b. Credit risk;

   c. Underwriting risk; and

   d. All other business risks and any other relevant risks as are set forth in the risk-based instructions;

   determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

4. An excess of capital over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules, and instructions referenced in this chapter is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the risk-based capital levels required by this chapter. Additional capital is used and is useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.

5. If a domestic insurer files a risk-based capital report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the risk-based capital report to correct the inaccuracy and notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. A risk-based capital report so adjusted is referred to as an adjusted risk-based capital report.

26.1-03.1-03. Company action level event.

1. "Company action level event" means any of the following events:

   a. The filing of a risk-based capital report by an insurer which indicates that:

      (1) The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital; or

      (2) If a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and two and one-half and has a negative trend;

   b. The notification by the commissioner to the insurer of an adjusted risk-based capital report that indicates an event in subdivision a, provided the insurer does not challenge the adjusted risk-based capital report under section 26.1-03.1-07; or

   c. If, under section 26.1-03.1-07, an insurer challenges an adjusted risk-based capital report that indicates the event in subdivision a, the notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

2. In the event of a company action level event, the insurer shall prepare and submit to the commissioner a risk-based capital plan that must:

   a. Identify the conditions that contribute to the company action level event;

   b. Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event;

   c. Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of

proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, or surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

d. Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

e. Identify the quality of, and problems associated with, the insurer's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

3. The risk-based capital plan must be submitted:

a. Within forty-five days of the company action level event; or

b. If the insurer challenges an adjusted risk-based capital report under section 26.1-03.1-07, within forty-five days after notification to the insurer that, after a hearing, the commissioner has rejected the insurer's challenge.

4. Within sixty days after the submission by an insurer of a risk-based capital plan to the commissioner, the commissioner shall notify the insurer whether the risk-based capital plan may be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the risk-based capital plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination, and may set forth proposed revisions that will render the risk-based capital plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised risk-based capital plan to the commissioner:

a. Within forty-five days after the notification from the commissioner; or

b. If the insurer challenges the notification from the commissioner under section 26.1-03.1-07, within forty-five days after a notification to the insurer that, after a hearing, the commissioner has rejected the insurer's challenge.

5. In the event of a notification by the commissioner to an insurer that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, subject to the insurer's right to a hearing under section 26.1-03.1-07, the commissioner may specify in the notification that the notification constitutes a regulatory action level event.

6. Every domestic insurer that files a risk-based capital plan or revised risk-based capital plan with the commissioner shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

a. The state has a risk-based capital provision substantially similar to subsection 1 of section 26.1-03.1-08; and

b. The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk-based capital plan or revised risk-based capital plan in that state no later than the later of:

(1) Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(2) The date on which the risk-based capital plan or revised risk-based capital plan is filed under subsections 3 and 4.

26.1-03.1-04. Regulatory action level event.

1. "Regulatory action level event" means, with respect to any insurer, any of the following events:

a. The filing of a risk-based capital report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital;

b. The notification by the commissioner to an insurer of an adjusted risk-based capital report that indicates the event in subdivision a, provided the insurer does not challenge the adjusted risk-based capital report under section 26.1-03.1-07;

c. If, under section 26.1-03.1-07, the insurer challenges an adjusted risk-based capital report that indicates the event in subdivision a, the notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge;

d. The failure of the insurer to file a risk-based capital report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

e. The failure of the insurer to submit a risk-based capital plan to the commissioner within the time period set forth in subsection 3 of section 26.1-03.1-03;

f. Notification by the commissioner to the insurer that:

(1) The risk-based capital plan or revised risk-based capital plan submitted by the insurer, in the judgment of the commissioner, is unsatisfactory; and

(2) The notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under section 26.1-03.1-07;

g. If, under section 26.1-03.1-07, the insurer challenges a determination by the commissioner under subdivision f, the

notification by the commissioner to the insurer that, after a hearing, the commissioner has rejected the challenge;

h. Notification by the commissioner to the insurer that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under section 26.1-03.1-07; or

i. If, under section 26.1-03.1-07, the insurer challenges a determination by the commissioner under subdivision h, the notification by the commissioner to the insurer that, after a hearing, the commissioner has rejected the challenge.

2. In the event of a regulatory action level event the commissioner shall:

a. Require the insurer to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;

b. Perform such examination or analysis of the assets, liabilities, and operations of the insurer including a review of its risk-based capital plan or revised risk-based capital plan as the commissioner deems necessary; and

c. Subsequent to the examination or analysis, issue an order specifying the corrective actions as the commissioner determines are required in a corrective order.

3. In determining corrective actions, the commissioner may take into account any factors deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan must be submitted:

a. Within forty-five days after the occurrence of the regulatory action level event;

b. If the insurer challenges an adjusted risk-based capital report under section 26.1-03.1-07 and the challenge is not judged to be frivolous by the commissioner, within forty-five days after the notification to the insurer that, after a hearing, the commissioner has rejected the insurer's challenge; or

c. If the insurer challenges a revised risk-based capital plan under section 26.1-03.1-07 and the challenge is not judged to be frivolous by the commissioner, within forty-five days after the notification to the insurer that, after a hearing, the commissioner has rejected the insurer's challenge.

4. The commissioner may retain actuaries and investment experts and other consultants as the commissioner judges to be necessary to review

the insurer's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or such other party as directed by the commissioner.

26.1-03.1-05. Authorized control level event.

1. "Authorized control level event" means any of the following events:

   a. The filing of a risk-based capital report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital;

   b. The notification by the commissioner to the insurer of an adjusted risk-based capital report that indicates the event in subdivision a, provided the insurer does not challenge the adjusted risk-based capital report under section 26.1-03.1-07;

   c. If, under section 26.1-03.1-07, the insurer challenges an adjusted risk-based capital report that indicates the event in subdivision a, notification by the commissioner to the insurer that, after a hearing, the commissioner has rejected the insurer's challenge;

   d. The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order provided the insurer has not challenged the corrective order under section 26.1-03.1-07; or

   e. If the insurer has challenged a corrective order under section 26.1-03.1-07 and, after a hearing, the commissioner has rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

2. In the event of an authorized control level event with respect to an insurer, the commissioner shall:

   a. Take such actions as are required under section 26.1-03.1-04 regarding an insurer with respect to which a regulatory action level event has occurred; or

   b. Take necessary action to cause the insurer to be placed under regulatory control under chapter 26.1-06.1 if the commissioner deems it to be in the best interests of the policyholders, creditors of the insurer, and the public. If the commissioner takes such actions, the authorized control level event must be deemed sufficient grounds for the commissioner to take action under chapter 26.1-06.1, and the commissioner has the rights, powers, and duties with respect to the insurer in chapter 26.1-06.1. If the commissioner takes action under this subdivision pursuant to an adjusted risk-based capital report, the insurer is entitled to any protection afforded to insurers under chapter 26.1-06.1 pertaining to summary proceedings.

26.1-03.1-06. Mandatory control level event.

1. "Mandatory control level event" means any of the following events:

   a. The filing of a risk-based capital report that indicates that the insurer's total adjusted capital is less than its mandatory control level risk-based capital;

   b. Notification by the commissioner to the insurer of an adjusted risk-based capital report that indicates the event in subdivision a, provided the insurer does not challenge the adjusted risk-based capital report under section 26.1-03.1-07; or

   c. If, under section 26.1-03.1-07, the insurer challenges an adjusted risk-based capital report that indicates the event in subdivision a, notification by the commissioner to the insurer that, after a hearing, the commissioner has rejected the insurer's challenge.

2. In the event of a mandatory control level event:

   a. With respect to a life insurer, the commissioner shall take actions as are necessary to place the insurer under regulatory control under chapter 26.1-06.1. In that event, the mandatory control level event must be deemed sufficient grounds for the commissioner to take action under chapter 26.1-06.1, and the commissioner has the rights, powers, and duties in chapter 26.1-06.1 with respect to the insurer. If the commissioner takes action pursuant to an adjusted risk-based capital report, the insurer is entitled to the protection of chapter 26.1-06.1 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

   b. With respect to a property and casualty insurer, the commissioner may take such actions as are necessary to place the insurer under regulatory control under section 26.1-06.1, or, in the case of an insurer that is not writing business and that is running off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event must be deemed sufficient grounds for the commissioner to take action under chapter 26.1-06.1 and the commissioner has the rights, powers, and duties in chapter 26.1-06.1 with respect to the insurer. If the commissioner takes action pursuant to an adjusted risk-based capital report, the insurer is entitled to the protection of chapter 26.1-06.1 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level events may be eliminated within the ninety-day period.

26.1-03.1-07. Hearings. Upon:

1. Notification to an insurer by the commissioner of an adjusted risk-based capital report;

2. Notification to an insurer by the commissioner that:

   a. The insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory; and

   b. Such notification constitutes a regulatory action level event with respect to the insurer;

3. Notification to any insurer by the commissioner that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its risk-based capital plan or revised risk-based capital plan; or

4. Notification to an insurer by the commissioner of a corrective order with respect to the insurer;

the insurer is entitled to a confidential departmental hearing, on a record, at which the insurer may challenge any determination or action by the commissioner. The insurer shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under subsection 1, 2, 3, or 4. Upon receipt of the insurer's request for a hearing, the commissioner must set a date for the hearing, which date must be no less than ten nor more than thirty days after the date of the insurer's request.

26.1-03.1-08. Confidentiality - Prohibition on announcements - Prohibition on use in ratemaking.

1. All risk-based capital reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and risk-based capital plans, including the results or report of any examination or analysis of an insurer performed under this chapter and any corrective order issued by the commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore must be kept confidential by the commissioner. This information may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner under this chapter or any other provision of the insurance laws of this state.

2. It is the judgment of the legislative assembly that the comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under this chapter, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television

station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is prohibited. However, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk-based capital levels, or any of them, or an inappropriate comparison of any other amount to the insurer's risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

3. It is the further judgment of the legislative assembly that the risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and may not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write.

26.1-03.1-09. Supplemental provisions - Rules - Exemption.

1. This chapter is supplemental to any other laws of this state, and does not preclude or limit any other powers or duties of the commissioner under these laws, including chapters 26.1-06.1 and 26.1-06.2.

2. The commissioner may adopt rules necessary for the implementation of this chapter.

3. The commissioner may exempt from the application of this chapter any domestic property and casualty insurer that:

   a. Writes direct business only in this state;

   b. Writes direct annual premiums less than an amount determined by the commissioner; and

   c. Assumes no reinsurance in excess of five percent of direct premium written.

26.1-03.1-10. Foreign insurers.

1. Upon the written request of the commissioner, any foreign insurer shall submit to the commissioner a risk-based capital report as of the end of the calendar year just ended, the later of:

   a. The date a risk-based capital report would be required to be filed by a domestic insurer under this chapter; or

b. Fifteen days after the request is received by the foreign insurer.

At the written request of the commissioner, any foreign insurer shall promptly submit to the commissioner a copy of any risk-based capital plan that is filed with the insurance commissioner of another state.

2. In the event of a company action level event, regulatory action level event, or authorized control level event, with respect to any foreign insurer as determined under the risk-based capital statute applicable in the state of domicile of the insurer, or, if no risk-based capital provision is in force in that state, under the provisions of this chapter, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under that state's risk-based capital statute, or, if no risk-based capital provision is in force in the state, the commissioner may require the foreign insurer to file a risk-based capital plan with the commissioner under section 26.1-03.1-03. In such event, the failure of the foreign insurer to file a risk-based capital plan with the commissioner is grounds to order the insurer to cease and desist from writing new insurance business in this state.

3. In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to the district court permitted under section 26.1-06.1-04 with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event is adequate grounds for the application.

26.1-03.1-11. Immunity. There is no liability on the part of, and no cause of action may arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

26.1-03.1-12. Notices. All notices by the commissioner to an insurer that may result in regulatory action hereunder are effective upon dispatch if transmitted by registered mail, or in the case of any other transmission is effective upon the insurer's receipt of the notice.

26.1-03.1-13. Phasein provision.

1. For risk-based capital reports required to be filed by life insurers with respect to 1993, the following requirements apply in lieu of the provisions of sections 26.1-03.1-03, 26.1-03.1-04, 26.1-03.1-05, and 26.1-03.1-06:

   a. In the event of a company action level event with respect to a domestic insurer, the commissioner may take no regulatory action hereunder.

   b. In the event of a regulatory action level event under subdivision a, b, or c of subsection 1 of section 26.1-03.1-04, the commissioner shall take the actions required under section 26.1-03.1-03.

c. In the event of a regulatory action level event under subdivision d, e, f, g, h, or i of subsection 1 of section 26.1-03.1-04 or an authorized control level event, the commissioner shall take the actions required under section 26.1-03.1-04 with respect to the insurer.

d. In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under section 26.1-03.1-05 with respect to the insurer.

2. For risk-based capital reports required to be filed by property and casualty insurers with respect to 1994, the following requirements apply in lieu of the provisions of sections 26.1-03.1-03, 26.1-03.1-04, 26.1-03.1-05, and 26.1-03.1-06:

a. In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

b. In the event of a regulatory action level event under subdivision a, b, or c of subsection 1 of section 26.1-03.1-04, the commissioner shall take the actions required under section 26.1-03.1-03.

c. In the event of a regulatory action level event under subdivision d, e, f, g, h, or i of subsection 1 of section 26.1-03.1-04 or an authorized control level event, the commissioner shall take the action required under section 26.1-03.1-05 with respect to the insurer.

SECTION 3. Chapter 26.1-10.1 of the North Dakota Century Code is created and enacted as follows:

26.1-10.1-01. Report.

1. Every insurer domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information purposes pursuant to other provisions of the insurance code, laws, rules, or other requirements.

2. The report required in subsection 1 is due within fifteen days after the end of the calendar month in which any of the foregoing transactions occur.

3. One complete copy of the report, including any exhibits or other attachments, must be filed with:

a. The insurance department of the insurer's state of domicile; and

b. The national association of insurance commissioners.

4. All reports obtained by or disclosed to the commissioner under this chapter must be given confidential treatment and are not subject to

subpoena and must not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer who would be affected notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by publication, in which event the commissioner may publish all or any part in the manner the commissioner deems appropriate.

26.1-10.1-02. Acquisitions and dispositions of assets.

1. Materiality. Acquisitions or dispositions of assets need not be reported under section 26.1-10.1-01 if the acquisitions or dispositions are not material. For purposes of this chapter, a material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period, or disposition, or the aggregate of any series of related dispositions during any thirty-day period, is one that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

2. Scope.

   a. Asset acquisitions subject to this chapter include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for this purpose.

   b. Asset dispositions subject to this chapter include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

3. Information to be reported.

   a. The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

      (1) Date of the transaction;

      (2) Manner of acquisition or disposition;

      (3) Description of the assets involved;

      (4) Nature and amount of the consideration given or received;

      (5) Purpose of, or reason for, the transaction;

      (6) Manner by which the amount of consideration was determined;

      (7) Gain or loss recognized or realized as a result of the transaction; and

(8) Names of the persons from whom the assets were acquired or to whom they were disposed.

b. Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

26.1-10.1-03. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

1. Materiality and scope.

a. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements need not be reported under section 26.1-10.1-01 if the nonrenewals, cancellations, or revisions are not material. For purposes of this chapter, a material nonrenewal, cancellation, or revision is one that affects:

(1) As respects property and casualty business, including accident and health business written by a property and casualty insurer:

(a) More than fifty percent of the insurer's total ceded written premium; or

(b) More than fifty percent of the insurer's total ceded indemnity and loss adjustment reserves.

(2) As respects life, annuity, and accident and health business, more than fifty percent of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement.

(3) As respects either property and casualty or life, annuity, and accident and health business, either of the following events constitutes a material revision that must be reported:

(a) An authorized reinsurer representing more than ten percent of a total cession is replaced by one or more unauthorized reinsurers; or

(b) Previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent of a total cession.

b. However, filing is not required if:

(1) As respects property and casualty business, including accident and health business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than ten percent of its total written premium for direct and assumed business; or

(2) As respects life, annuity, and accident and health business, the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of the statutory reserve requirement prior to any cession.

2. Information to be reported.

a. The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(1) Effective date of the nonrenewal, cancellation, or revision;

(2) The description of the transaction with an identification of the initiator of the transaction;

(3) Purpose of, or reason for, the transaction; and

(4) If applicable, the identity of the replacement reinsurers.

b. Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year which are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Approved March 24, 1995
Filed March 27, 1995

CHAPTER 280

SENATE BILL NO. 2360

(Senator Lips)
(Representatives Wald, Payne)

INSURANCE CONSOLIDATION OR REINSURANCE HEARINGS

AN ACT to create a new section to chapter 26.1-07 of the North Dakota Century Code, relating to hearing on petition and duties of the insurance commissioner; to amend and reenact sections 26.1-07-01, 26.1-07-02, and 26.1-07-04 of the North Dakota Century Code, relating to consolidation or reinsurance of domestic insurance companies; and to repeal section 26.1-07-05 of the North Dakota Century Code, relating to hearings on petition and duties of the insurance commissioner.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-07-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-07-01. Domestic companies - Consolidation - Reinsurance. As used in this chapter, "consolidate" includes consolidation and merger and "reinsurance" ~~refers to reinsurance~~ includes only those obligations ceded or assumed by an assumption agreement. An "assumption agreement" is one that transfers all of the direct insurer's obligations under policies of insurance to another insurer and relieves the transferring insurer of any obligations under the policies. A domestic insurance company organized on the stock, mutual, stipulated premium, or assessment plan may not consolidate with any other company, or reinsure its risks or any part thereof with any other company, or assume or reinsure the whole or any portion of the risks of any other company, except in the manner provided by this chapter. ~~This chapter does not prevent a company, whether organized on the stock or mutual plan, from reinsuring a fractional part of any single risk.~~

SECTION 2. AMENDMENT. Section 26.1-07-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-07-02. Petition for allowance of consolidation or reinsurance. When any company described in section 26.1-07-01 proposes to consolidate with any other company, or to enter into any contract of reinsurance, it must file its petition with the commissioner setting forth the terms and conditions of the proposed consolidation or reinsurance contract and asking for approval or modification as provided by this chapter. The company shall file as an exhibit to the petition the proposed consolidation or reinsurance contract.

SECTION 3. AMENDMENT. Section 26.1-07-04 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-07-04. Notice of petition for consolidation or reinsurance. When a petition is filed, the commissioner, within thirty days after filing of the petition, shall issue an order requiring notice by mail to each policyholder of the ~~petitioning~~ domestic company if any of its policyholders are being reinsured or it is proposing to consolidate with another company, of the pendency of the petition and of the time

when and place where a hearing on the petition will be held. The hearing must be scheduled not more than ninety days from the date of the order. The commissioner shall publish the order of notice and the petition in five newspapers, one of which must be a daily newspaper published at the state capital, at least two weeks before the hearing upon the petition. By mutual agreement between the petitioning company and the commissioner, the time frame set forth in this section may be modified, changed, or extended.

SECTION 4. A new section to chapter 26.1-07 of the North Dakota Century Code is created and enacted as follows:

Hearing on petition - General duties of commissioner. The commissioner shall hold a hearing on the petition and determine whether the consolidation or reinsurance will be allowed. The hearing must be conducted under chapter 28-32. Within sixty days of the close of the hearing, the commissioner shall enter findings of fact, conclusions of law, and an order either approving or disapproving any petition. The commissioner in making the determination shall consider the following:

1. Whether the proposed consolidation or reinsurance contract is inequitable to the policyholders of any domestic insurance company involved;

2. Whether the proposed consolidation or reinsurance contract would materially reduce the financial security of policyholders of the domestic insurer in this state or elsewhere; and

3. Whether the competence, experience, and integrity of the persons of a foreign insurance company who would control the operation of the consolidated insurance company or the reinsuring company are such that it would not be in the interest of the policyholders of the company to permit the consolidation or reinsurance contract.

The findings of fact, conclusions of law, and order entered by the commissioner are subject to appeal under chapter 28-32.

SECTION 5. REPEAL. Section 26.1-07-05 of the North Dakota Century Code is repealed.

Approved March 24, 1995
Filed March 27, 1995

CHAPTER 281

HOUSE BILL NO. 1205

(Representatives Wald, Froseth, Carlson, Skarphol)
(Senators Mutch, Krebsbach)

INSURANCE BROKER COVERAGE AND LICENSING

AN ACT to create and enact two new sections to chapter 26.1-26 of the North Dakota Century Code, relating to license requirements for insurance brokers and payment of insurance commissions by insurance brokers; and to amend and reenact section 26.1-26-18 of the North Dakota Century Code, relating to bond requirements for insurance brokers and surplus lines insurance brokers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-26 of the North Dakota Century Code is created and enacted as follows:

Errors and omissions insurance - License requirement for insurance brokers. Each insurance broker or surplus lines insurance broker shall file a certificate of insurance with the commissioner, and shall keep in force for as long as the license remains in effect, an errors and omissions insurance policy in an amount not less than five hundred thousand dollars.

SECTION 2. A new section to chapter 26.1-26 of the North Dakota Century Code is created and enacted as follows:

Payment of commissions by brokers - Limitations. No surplus lines insurance broker or insurance broker may pay, directly or indirectly, any commission, brokerage, or other valuable consideration to any person for services as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker within this state unless the person receiving the payment held at the time the services were performed a valid license as a surplus lines insurance broker or insurance broker as required by the laws of this state. A person licensed as an insurance agent or a limited insurance representative under this chapter at the time the services were performed may not accept any commission, brokerage, or other valuable consideration paid in violation of this section.

SECTION 3. AMENDMENT. Section 26.1-26-18 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-18. License requirement - Brokers - Bond - ~~Waiver for nonresident insurance broker~~. ~~Prior to~~ Before issuance of a license as an insurance broker, the applicant shall file with the commissioner, and ~~thereafter,~~ for as long as the license remains in effect, shall keep in force, a bond in the penal sum of ~~not less than two~~ five thousand dollars with authorized corporate surety approved by the commissioner. ~~Prior to~~ Before issuance of a license as a surplus lines insurance broker, the applicant shall file with the commissioner, and ~~thereafter,~~ for as long as the license remains in effect, shall keep in force, a bond in the penal sum of not less than ~~an amount equal to the taxes paid to the commissioner the previous year as required by section 26.1-44-06, with a minimum bond of five hundred dollars and a maximum bond of twenty~~ five thousand dollars ~~required. The commissioner shall~~

~~set the bond for a surplus lines insurance broker not previously licensed or whose license has lapsed, but the bond may not be less than five hundred dollars nor greater than twenty thousand dollars~~ with authorized corporate surety approved by the commissioner. The aggregate liability of the surety for claims on any bond may not exceed the penal sum of the bond. No bond may be terminated unless at least thirty days' prior written notice is given by the surety to the licensee and the commissioner. Upon termination of the license for which the bond was in effect, the commissioner shall notify the surety within ten working days. Any licensee who is the holder of a license as an insurance broker and a license as a surplus lines insurance broker may satisfy the bonding requirements by a single bond in the penal sum of not less than ~~twenty~~ ten thousand dollars.

~~Notwithstanding other provisions of this chapter, no new bond may be required for a nonresident insurance broker if the commissioner is satisfied that the existing bond covers the broker's insurance business in this state.~~

Approved March 29, 1995
Filed March 29, 1995

CHAPTER 282

HOUSE BILL NO. 1194

(Representatives Payne, Wald, Byerly)
(Senators Lips, Tallackson, Nething)

STATUTE OF LIMITATIONS FOR INSURANCE AGENTS

AN ACT to create and enact a new section to chapter 26.1-26 of the North Dakota Century Code, relating to a statute of limitations for insurance agents and brokers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-26 of the North Dakota Century Code is created and enacted as follows:

Statute of limitations. A civil action for the recovery of damages resulting from negligence or breach of contract brought against any person licensed under this chapter by any person claiming to have been injured as a result of the providing of insurance services or the failure to provide insurance services by a licensee may not be commenced in this state after July 31, 1995, unless the action is commenced on or before the earlier of:

1. Two years from the date the alleged act, omission, or neglect is discovered or should have been discovered by the exercise of reasonable diligence; or

2. Six years after performance of the service for which the claim for relief arises, unless discovery was prevented by the fraudulent conduct of the licensee.

Approved April 4, 1995
Filed April 4, 1995

CHAPTER 283

HOUSE BILL NO. 1184

(Representatives Grosz, Galvin, Delzer)
(Senators Christmann, Freborg)

BOILER INSPECTION AND CERTIFICATES

AN ACT to amend and reenact sections 26.1-22.1-07 and 26.1-22.1-10 of the North Dakota Century Code, relating to inspection of boilers and certificates of inspection.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-22.1-07 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-22.1-07. Inspection of boilers.

1. The chief boiler inspector shall inspect each boiler used or proposed to be used within this state. The inspection must be thorough as to the construction, installation, condition, and operation as provided by the rules adopted to implement this chapter. An exempt boiler may be inspected by the chief boiler inspector when the owner, the owner's agent, or the user of the boiler makes written request for inspection to the commissioner.

2. Each boiler of one hundred thousand pounds [45359.24 kilograms] per hour or more capacity, used or proposed to be used within this state, which has internal continuous water treatment under the direct supervision of a graduate engineer or chemist, or one having equivalent experience in the treatment of boiler water where the water treatment is for the purpose of controlling and limiting serious corrosion and other deteriorating factors, and with respect to which boiler the chief boiler inspector has determined that the owner or user has complied with the prescribed recordkeeping requirements, must be inspected at least once every ~~twenty-four~~ thirty-six months internally ~~and externally~~ while not under pressure, and at least once every ~~eighteen~~ twelve months externally while under pressure. If a hydrostatic test is necessary to determine the safety of a boiler, the test must be conducted by the owner or user of the equipment under the supervision of the chief boiler inspector. The owner or user of a boiler of one hundred thousand pounds [45359.24 kilograms] per hour or more capacity desiring to qualify for ~~twenty-four months~~ thirty-six month internal inspection intervals shall keep available for examination by the chief boiler inspector accurate records showing the date and actual time the boiler is out of service and the reason or reasons therefor, and the results of the chemical and physical ~~laboratory~~ analysis ~~of samples~~ of the boiler water, whether from laboratory analysis of samples taken at regular intervals of not more than forty-eight hours ~~of operation as~~ or from continuous on-line analysers, that will adequately show the condition of the water and any other elements or characteristics of the water capable of producing corrosion or other deterioration of the boiler or its parts.

3. In the event an inspection discloses deficiencies in equipment or in operating procedures, inspections may be required once every twelve months.

SECTION 2. AMENDMENT. Section 26.1-22.1-10 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-22.1-10. Certificate of inspection - Certificate to be posted. The commissioner shall issue a certificate of inspection for each boiler inspected upon receipt of an inspection report certifying that the ~~boilers~~ ~~are~~ boiler is in a safe condition to be operated. The commissioner shall charge a fee of fifteen dollars for each certificate of inspection issued as the result of inspections authorized under section 26.1-22.1-08. The fees are the liability of the insurance company or self-insured company and must be paid in accordance with rules adopted by the commissioner. No certificate may be issued for any boiler not in a safe condition to be operated. No certificate is valid for a period of more than thirty-six months for power boilers described in subsection 2 of section 26.1-22.1-07, and no more than twelve months for other power boilers, twenty-four months for steam traction engines, and thirty-six months for low pressure boilers except that a two-month grace period may be extended for any certificate. Upon written request from a special inspector, the chief boiler inspector may issue a short-term certificate. Each certificate of inspection must be posted conspicuously under glass in the boiler room or adjacent to the boiler inspected.

Approved March 24, 1995
Filed March 27, 1995

CHAPTER 284

HOUSE BILL NO. 1393
(Representative Payne)

INSURABLE INTEREST OF CORPORATION OR TRUSTEE

AN ACT to amend and reenact subsection 3 of section 26.1-29-09.1 of the North Dakota Century Code, relating to the definition of insurable interest for purposes of personal insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-29-09.1 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

3. "Insurable interest", with reference to personal insurance, includes only the following interests:

   a. In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection.

   b. In the case of persons other than those described in subdivision a, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest that would arise only by, or would be enhanced in value by, the death, disablement, or injury of the individual insured.

   c. In the case of individual parties to a contract or option for the purchase or sale of an interest in a business partnership or firm, of a membership interest in a limited liability company, or of shares of stock of a closed corporation or of an interest in the shares, an interest in the life of each individual party to the contract for the purpose of the contract only, in addition to an insurable interest that may otherwise exist as to the life of the individual.

   d. In the case of religious, educational, eleemosynary, charitable, or benevolent organizations, a lawful interest in the life of the individual insured if that individual has executed a written consent to the insurance contract.

   e. In the case of a corporation or the trustee of a trust providing life, health, disability, retirement, or similar benefits to employees of one or more corporations, and acting in a fiduciary capacity with respect to the employees, retired employees, or their dependents or beneficiaries, a corporation or the trustee of a trust has an insurable interest in the lives of employees for whom the benefits are to be provided and the corporation or trustee of a trust may purchase, accept, or otherwise acquire an interest in personal insurance as a beneficiary or owner. The consent of the insured individual is

required if the personal insurance purchased names the corporation or the trustee of a trust as a beneficiary. The consent requirement is satisfied if the insured individual is provided written notice of the coverage and does not reject the coverage within thirty days of receipt of the notice.

Approved March 21, 1995
Filed March 21, 1995

CHAPTER 285

SENATE BILL NO. 2129

(Senator Lips)
(Representatives Wald, Walker)

DOMESTIC CEDING INSURER CREDIT

AN ACT to amend and reenact subdivision a of subsection 4 of section 26.1-31.2-01 of the North Dakota Century Code, relating to credit allowed a domestic ceding insurer; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subdivision a of subsection 4 of section 26.1-31.2-01 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

4. a. Credit must be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in subsection 2 of section 26.1-31.2-03, for the payment of valid claims of its United States policyholders and ceding insurers, their assigns, and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars. In the case of a group ~~of~~, including incorporated and individual unincorporated underwriters, the trust must consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars must be held jointly for the benefit of United States ceding insurers of any member of the group; the incorporated members of the group may not be engaged in any business other than underwriting as a member of the group and are subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and the group shall make available to the commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accountants.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

Approved March 6, 1995
Filed March 6, 1995

CHAPTER 286

HOUSE BILL NO. 1155

(Industry, Business and Labor Committee)
(At the request of the Commissioner of Insurance)

VIATICAL SETTLEMENTS

AN ACT to create and enact chapter 26.1-33.1 of the North Dakota Century Code, relating to viatical settlements; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-33.1 of the North Dakota Century Code is created and enacted as follows:

26.1-33.1-01. Definitions.

1. "Person" means any natural or artificial entity, including individuals, partnerships, associations, trusts, or corporations.

2. "Viatical settlement broker" means an individual, partnership, corporation, or other entity who or which for another and for a fee, commission, or other valuable consideration, offers or advertises the availability of viatical settlements, introduces viators to viatical settlement providers, or offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement provider. Viatical settlement broker does not include an attorney, accountant, or financial planner retained to represent the viator whose compensation is not paid by the viatical settlement provider.

3. "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider and a person owning a life insurance policy or who owns or is covered under a group policy insuring the life of a person who has a catastrophic or life-threatening illness or condition. The agreement must establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the policyowner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

4. "Viatical settlement provider" means an individual, partnership, corporation, or other entity that enters into an agreement with a person owning a life insurance policy or who owns or is covered under a group policy insuring the life of a person who has a catastrophic or life-threatening illness or condition, under the terms of which the viatical settlement provider pays compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the policyowner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider. Viatical settlement provider does not include:

a. Any bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

b. The issuer of a life insurance policy providing accelerated benefits; or

c. Any natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

5. "Viator" means the owner of a life insurance policy insuring the life of a person with a catastrophic or life-threatening illness or condition or the certificate holder who enters into an agreement under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

26.1-33.1-02. License requirements - Penalty.

1. No individual, partnership, corporation, or other entity may act as a viatical settlement provider or enter into or solicit a viatical settlement contract without first having obtained a license from the commissioner.

2. Application for a viatical settlement provider license must be made to the commissioner by the applicant on a form prescribed by the commissioner, and the application must be accompanied by a fee of two hundred fifty dollars.

3. Licenses may be renewed from year to year on the anniversary date upon payment of an annual renewal fee of one hundred fifty dollars. Failure to pay the fee within the term prescribed results in the automatic revocation of the license.

4. Upon the filing of an application and payment of the license fee, the commissioner shall issue a license if the commissioner finds that the applicant:

a. Has provided a detailed plan of operation;

b. Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

c. Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied for; and

d. If a corporation, is a corporation incorporated under the laws of this state or a foreign corporation authorized to transact business in this state.

5. The commissioner may not issue a license to a nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the commissioner or the applicant has filed with the

commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner of insurance.

6. A person may not act as or hold oneself out to be a viatical settlement provider unless licensed under this chapter. Any person willfully violating this section is guilty of a class C felony.

26.1-33.1-03. License revocation.

1. The commissioner may suspend, revoke, or refuse to renew the license of any viatical settlement provider if the commissioner finds that:

   a. There was any misrepresentation in the application for the license;

   b. The holder of the license has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a viatical settlement provider;

   c. The licensee demonstrates a pattern of unreasonable payments to policyowners;

   d. The licensee has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

   e. The licensee has violated any of the provisions of this chapter.

2. Before the commissioner may deny a license application or suspend, revoke, or refuse to renew the license of a viatical settlement provider, the commissioner shall conduct a hearing in accordance with chapter 28-32.

26.1-33.1-04. Approval of viatical settlement contracts. A viatical settlement provider may not use any viatical settlement contract in this state unless it has been filed with and approved by the commissioner. Any viatical settlement contract form filed with the commissioner must be deemed approved if it has not been disapproved within sixty days of filing. The commissioner shall disapprove a viatical settlement contract form if the contract or provisions contained in the contract are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the policyowner.

26.1-33.1-05. Reporting requirements. Each licensee shall file with the commissioner on or before March first of each year an annual statement containing the following information regarding business transacted in this state for the previous calendar year:

1. For each policy viaticated:

   a. The date the viatical settlement was entered into.

   b. The life expectancy of viator at time of contract.

   c. The face amount of policy.

d. The amount paid by the viatical settlement provider to viaticate the policy and the percentage that amount represents of the face amount.

e. If the viator has died:

(1) The date of death.

(2) The total insurance premiums paid by viatical settlement provider to maintain the policy in force.

2. A breakdown, by disease category, of applications received, accepted, and rejected.

3. A breakdown of policies viaticated by issuer and policy type.

4. The number of secondary market versus primary transactions.

5. The total number of policies viaticated.

6. The amount of outside borrowings.

26.1-33.1-06. Examination.

1. When the commissioner deems it reasonably necessary to protect the interests of the public, the commissioner may examine the business and affairs of any licensee or applicant for a license. The commissioner may order any licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination must be paid by the licensee or applicant.

2. Names and individual identification data for all viators are not subject to section 44-04-18 and are private and confidential information and may not be disclosed by the commissioner, unless required by law.

3. Records of all transactions of viatical settlement contracts must be maintained by the licensee and must be made available to the commissioner for inspection during reasonable business hours.

26.1-33.1-07. Disclosure. A viatical settlement provider shall disclose the following information to the viator no later than the date the viatical settlement contract is signed by all parties:

1. Possible alternatives to viatical settlement contracts for persons with catastrophic or life-threatening illnesses, including accelerated benefits offered by the issuer of the life insurance policy.

2. The fact that some or all of the proceeds of the viatical settlement may be taxable and that assistance should be sought from a personal tax advisor.

3. The fact that the viatical settlement may be subject to the claims of creditors.

4. The fact that receipt of a viatical settlement may adversely affect the recipients' eligibility for medicaid or other government benefits or entitlements and that advice should be obtained from the appropriate agencies.

5. The policyowner's right to rescind a viatical settlement contract within thirty days of the date it is executed by all parties or fifteen days of the receipt of the viatical settlement proceeds by the viator, whichever is less, as provided in section 26.1-33.1-08.

6. The date by which the funds will be available to the viator and the source of the funds.

26.1-33.1-08. General rules.

1. A viatical settlement provider entering into a viatical settlement contract with any person with a catastrophic or life-threatening illness or condition shall first obtain:

   a. A written statement from a licensed attending physician that the person is of sound mind and under no constraint or undue influence; and

   b. A witnessed document in which the person consents to the viatical settlement contract, acknowledges the catastrophic or life-threatening illness, represents the person has a full and complete understanding of the viatical settlement contract, has a full and complete understanding of the benefits of the life insurance policy, releases that person's medical records, and acknowledges that the person has entered into the viatical settlement contract freely and voluntarily.

2. All medical information solicited or obtained by any licensee is subject to the applicable provision of state law relating to confidentiality of medical information.

3. All viatical settlement contracts entered into in this state must contain an unconditional refund provision of at least thirty days from the date of the contract or fifteen days of the receipt of the viatical settlement proceeds, whichever is less.

4. Immediately upon receipt from the viator of documents to effect the transfer of the insurance policy, the viatical settlement provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a bank, pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent shall transfer the proceeds due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer.

5. Failure to tender the viatical settlement by the date disclosed to the viator renders the contract null and void.

26.1-33.1-09. Unfair trade practices. A violation of this chapter is an unfair trade practice under chapter 26.1-04 subject to the penalties contained in that chapter.

26.1-33.1-10. Applicability of chapter. A viatical settlement provider transacting business in this state may not continue to do so after August 1, 1995, unless the provider complies with this chapter.

Approved April 11, 1995
Filed April 12, 1995

CHAPTER 287

SENATE BILL NO. 2230

(Senators DeMers, Thane)
(Representatives Christenson, Price)

HEALTH INSURANCE COVERAGE FOR NEWBORNS AND ADOPTED CHILDREN

AN ACT to amend and reenact section 26.1-36-07 of the North Dakota Century Code, relating to health insurance coverage for newborn and adopted children.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-07. Health insurance coverage for newborn and adopted children - Scope of coverage - Notification of birth or adoption.

1. All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which ~~provides~~ provide coverage for a family member of the insured or subscriber must, as to the family members' coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth and are also payable from the date of physical placement by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 with respect to an adopted child.

2. The coverage for newly born children and for children placed for adoption by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or child placed for adoption by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth or date of physical placement by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 of the child in order to have the coverage continue beyond the thirty-one-day period.

Approved March 24, 1995
Filed March 27, 1995

CHAPTER 288

SENATE BILL NO. 2480

(Senators Grindberg, DeMers, Thane)
(Representatives Christopherson, Kerzman)

SUBSTANCE ABUSE INSURANCE COPAYMENTS

AN ACT to create and enact a new subdivision to subsection 2 of section 26.1-36-08 and a new paragraph to subdivision e of subsection 2 of section 26.1-36-09 of the North Dakota Century Code, relating to copayments for treatment of substance abuse outside a preferred provider network.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[155] **SECTION 1.** A new subdivision to subsection 2 of section 26.1-36-08 of the North Dakota Century Code is created and enacted as follows:

If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those visits after the first five visits in any calendar year.

[156] **SECTION 2.** A new paragraph to subdivision e of subsection 2 of section 26.1-36-09 of the 1993 Supplement to the North Dakota Century Code is created and enacted as follows:

If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those hours after the first five hours in any calendar year.

Approved April 12, 1995
Filed April 13, 1995

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[155] Section 26.1-36-08 was also amended by section 2 of House Bill No. 1058, chapter 243.

[156] Section 26.1-36-09 was also amended by section 1 of Senate Bill No. 2292, chapter 289; section 2 of House Bill No. 1058, chapter 243; and section 5 of Senate Bill No. 2080, chapter 329.

CHAPTER 289

SENATE BILL NO. 2292

(Senators Mathern, Goetz, Nalewaja)
(Representatives Olson, Gulleson, Sandvig)

MENTAL DISORDER INSURANCE COVERAGE

AN ACT to amend and reenact subsection 2 of section 26.1-36-09 of the North Dakota Century Code, relating to group health policy and health service contract mental disorder coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[157] **SECTION 1. AMENDMENT.** Subsection 2 of section 26.1-36-09 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

2. a. The benefits must be provided for inpatient treatment and treatment by partial hospitalization and outpatient treatment.

   b. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of sixty days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined in subsection 25 of section 52-01-01 and the state department of health and consolidated laboratories' rules pursuant thereto offering treatment for the prevention or cure of mental disorder or other related illness.

   c. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined in subsection 25 of section 52-01-01 and the state department of health and consolidated laboratories' rules pursuant thereto or by a regional human service center licensed under section 50-06-05.2, offering treatment for the prevention or cure of mental disorder or other related illness. For services provided in regional human service centers, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

   d. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization; provided, however, that no more than forty-six days of the inpatient treatment benefits required by this section may be traded for treatment by partial hospitalization.

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[157] Section 26.1-36-09 was also amended by section 2 of House Bill No. 1058, chapter 243; section 2 of Senate Bill No. 2480, chapter 288; and section 5 of Senate Bill No. 2080, chapter 329.

e. (1) In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of thirty hours for services covered under this section in any calendar year if the treatment services are provided within the scope of licensure by a nurse who holds advanced licensure with a scope of practice within mental health or if the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, or a licensed certified social worker who:

(a) Possesses a master's or doctorate degree in social work from an institution accredited by the council of social work education;

(b) Has at least one year of direct clinical social work practice during graduate school or one year of postgraduate supervised clinical social work practice in a structured teaching environment;

(c) Has completed at least ~~seven thousand five hundred hours of post social work graduate degree~~ the equivalent of four years of full-time supervised clinical social work experience ~~obtained~~ within ~~five~~ the last seven years ~~with at least three thousand hours direct clinical social work practice within the last ten years~~;

(d) Has ~~at least three thousand hours post social work graduate degree supervised practice experience obtained within two years, one thousand five hundred hours of which must have been under the supervision of a qualified clinical social worker~~ passed the clinical examination or its equivalent offered by the North Dakota board of social work examiners; and

(e) If not licensed in this state, is licensed, certified, or registered at the highest level of social work practice in another state.

(2) A person who is a licensed certified social worker on August 1, 1995, is exempt from subparagraphs c and d. Supervision under subparagraph c may be provided by a qualified clinical social worker, a licensed psychologist, or a licensed psychiatrist, but the preferred supervisor is the qualified clinical social worker.

(3) Upon the request of an insurance company, a nonprofit health service corporation, or a health maintenance organization the North Dakota board of social work examiners shall provide to the requesting entity information to certify that a licensed certified social worker meets the qualifications required under this section.

~~(3)~~ (4) The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a

deductible or a copayment for the first five hours in any calendar year, and may not establish a copayment greater than twenty percent for the remaining hours.

f. "Partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

Approved March 13, 1995
Filed March 13, 1995

CHAPTER 290

SENATE BILL NO. 2462

(Senators C. Nelson, DeMers, Robinson)
(Representatives Clayburgh, Monson, Svedjan)

INSURANCE COVERAGE FOR CERTAIN DISORDERS

AN ACT to amend and reenact sections 26.1-36-09.3 and 54-52.1-04.6 of the North Dakota Century Code, relating to insurance coverage for treatment of certain disorders.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-09.3 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.3. Coverage for treatment of certain disorders. Except for policies ~~which~~ that only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or a subscriber contract provided by a nonprofit health service corporation, preferred provider organization, or health maintenance organization, may be issued, renewed, continued, delivered, issued for delivery, or executed in this state after January 1, 1990, unless the policy, certificate, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage must be the same as that for treatment to any other joint in the body, and applies if the treatment is administered or prescribed by a physician or a dentist. Benefits for the coverage may be limited to a lifetime maximum of ~~eight~~ ten thousand dollars per person for surgery, and two thousand five hundred dollars for nonsurgical treatment.

SECTION 2. AMENDMENT. Section 54-52.1-04.6 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.6. Coverage for treatment of certain disorders. The board shall provide coverage under either a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage must be the same as that for treatment to any other joint in the body, and applies if the treatment is administered or prescribed by a physician or a dentist. Benefits for the coverage may be limited to a lifetime maximum of ~~eight~~ ten thousand dollars per person for surgery, and two thousand five hundred dollars for nonsurgical treatment.

Approved March 17, 1995
Filed March 20, 1995

CHAPTER 291

HOUSE BILL NO. 1327

(Representatives Wald, Payne, Freier)

HEALTH INSURANCE POLICY LOSS RATIOS

AN ACT to amend and reenact section 26.1-36-37.2 of the North Dakota Century Code, relating to loss ratios on health insurance policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-37.2 of the 1993 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36-37.2. Loss ratios - Rules. For all policies providing hospital, surgical, medical, or major medical benefit, an insurance company, a nonprofit health service corporation, a fraternal benefit society, and any other entity providing a plan of health insurance or health benefit subject to state insurance regulation shall return benefits to group policyholders in the aggregate of not less than seventy-five percent of premium received and to individual policyholders in the aggregate of not less than sixty-five percent of premium received. The commissioner shall adopt rules to establish these minimum standards on the basis of incurred claims experienced and earned premiums for the entire period for which rates are computed to provide coverage in accordance with accepted actuarial principles and practices. This section does not apply to any contract or plan of insurance that provides exclusively for accident, disability income insurance, specified disease, hospital confinement indemnity, or other limited benefit health insurance.

Approved March 21, 1995
Filed March 21, 1995

CHAPTER 292

HOUSE BILL NO. 1243
(Representative Kretschmar)

AIRCRAFT AFTERMARKET RISK CONTRACTS

AN ACT relating to aftermarket risk contracts and insurance requirements for purchasers of aircraft and aircraft components manufactured in this state.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in this Act:

1. "Aftermarket risk insurance" means aircraft and aircraft component product and completed operations liability insurance that conforms with sections 2 and 3 of this Act.

2. "Aircraft" means general aviation light craft that is powered and intended to fly above the ground; is designed to carry one person or more, but with a maximum seating capacity of fewer than twenty passengers; and weighs less than twelve thousand five hundred pounds [5669.9 kilograms].

3. "Aircraft component" means a manufactured part or assembly intended for use in the construction, replacement, or repair of an aircraft. The term includes any complete aircraft subsystem, including the aircraft engine, that carries its own manufacturer's warranty or services provided separately from the warranty of the manufacturer of the aircraft.

4. "Aviation manufacturer" means a manufacturer of aircraft or aircraft components who has its place of manufacture and place of production of aircraft or aircraft components located within this state. The term includes a manufacturer located in this state who imports raw materials, components, and aircraft subassemblies from outside the state for manufacturing purposes. The term also includes a person who modifies, maintains, alters, repairs, or installs aircraft components in aircraft in accordance with federal aviation administration regulations and holds a repair station certificate issued by the federal aviation administration.

SECTION 2. North Dakota aftermarket risk contract. The sale of aircraft and aircraft components sold by an aviation manufacturer and the performance of any modification, maintenance, alteration, repair, or installation of components in aircraft in this state are governed by an aftermarket risk contract. The contract between the seller or aviation manager and the purchaser must be executed at the time of purchase and reconsidered at each subsequent resale. The first and subsequent seller or aviation manufacturer shall agree to be bound by North Dakota law and the aftermarket risk contract or to provide a fully paid aftermarket product liability insurance policy that covers exposure to tort liability within the United States. The option of providing the insurance policy applies only to aircraft or aircraft components that sell for more than two thousand dollars.

SECTION 3. Aftermarket risk insurance requirements - Encumbrances.

1. An aftermarket risk insurance policy purchased pursuant to section 2 of this Act must hold harmless all aviation manufacturers that manufactured, modified, maintained, repaired, or altered the aircraft or aircraft component assembled or first sold in this state.

2. The aviation manufacturer or seller of the aircraft or aircraft component may offer in the sales contract aftermarket risk insurance based on continued choice of North Dakota law. The aftermarket risk insurance option must be attached to the original sales contract as a lien on the aircraft holding the first owner and each subsequent owner financially responsible for the cost of purchasing and maintaining aftermarket risk insurance and binding the owner to governance by North Dakota law. An aftermarket insurance obligation must be recorded as a lien on the aircraft at the federal aviation administration aircraft registry.

SECTION 4. Stabilization of aftermarket risk insurance market.

1. An aviation manufacturer and a purchaser of an aircraft or aircraft component which intend to be bound by North Dakota law must be covered by insurance that meets the requirements of insurance laws of this state. The sales contract must include a dispute resolution procedure for aftermarket risk contracts and insurance contracts.

2. An aftermarket risk insurance provider domiciled in this state may limit coverage to include any caps and limitations permitted by law at the time of the first sale of the product.

3. Upon resale of an aircraft or aircraft component, the purchaser agrees to purchase insurance and the insurance carrier shall provide evidence of coverage. A default on the insurance may reinstate, by contract, the lien back to the aviation manufacturer. An aftermarket risk contract may include a requirement for removal of the aircraft or aircraft component from service, consent to be governed by North Dakota law, and purchase of additional passenger and public risk insurance coverage.

4. An aviation manufacturer or value-added reseller shall provide confidential access to data necessary for actuarial analysis by aftermarket insurance carriers to assist in maintaining a competitive insurance market with a choice of alternative carriers.

SECTION 5. Financial responsibility. An owner of an aircraft or aircraft component manufactured in this state shall provide proof of financial responsibility in the amount of one hundred thousand dollars, per occurrence, for property damage and personal injury or death on the ground resulting from the use of the aircraft or aircraft component.

Approved April 4, 1995
Filed April 4, 1995

CHAPTER 293

SENATE BILL NO. 2499
(Senator Lips)

HEALTH PROVIDER COOPERATIVES

AN ACT to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to health provider cooperatives; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new chapter to title 26.1 of the North Dakota Century Code is created and enacted as follows:

Definitions. As used in this chapter:

1. "Commissioner" means the commissioner of insurance.

2. "Health care provider" means any person or institution licensed to provide health care services in this state.

3. "Health provider cooperative" means a corporation organized under this chapter and operated on a cooperative plan to provide health care services to purchasers of those services.

4. "Member" means a licensed health care provider or an organization owned, controlled, or affiliated with a health care provider, including without limitation, a professional corporation, partnership, or other similar organization.

Organization - Licensure. A health provider cooperative shall organize under chapter 10-15 unless otherwise provided in this chapter. After incorporation the health provider cooperative is subject to chapter 10-15 unless otherwise provided in this chapter. If a provision of this chapter conflicts with chapter 10-15, the provision of this chapter applies. A health provider cooperative organized under this chapter is not an insurance company under chapter 26.1-12, a health maintenance organization under chapter 26.1-18.1, or a nonprofit health service corporation under chapter 26.1-17. A health provider cooperative does not violate limitations on the corporate practice of medicine.

Powers. In addition to the powers granted a cooperative under chapter 10-15, a health provider cooperative has the powers granted a nonprofit corporation under chapter 10-24. The power granted under chapter 10-15 controls over any inconsistent power granted by chapter 10-24.

Provider contracts. A health provider cooperative and its members may execute service contracts permitting the provider members to provide some or all of their health care services through the health provider cooperative to the enrollees, members, subscribers, or insureds of a nonprofit health service plan, health maintenance organization, accident and health insurance company, or the state medical assistance program. Each purchaser may execute contracts for the purchase of health services from a health provider cooperative in accordance with this section.

A contract between a health provider cooperative and a purchaser must provide for payment by the purchaser on a substantially capitated or similar risk-sharing basis.

1. Every contract between a health provider cooperative and a purchaser must be in writing and must provide that if the purchaser fails to pay for health care services as set forth in the contract, the enrollee is not liable to the provider for any sums owed by the purchaser.

2. A member provider, agent, trustee, or assignee thereof, may not maintain any action at law against an enrollee to collect sums owed by the purchaser.

Contract filing - Approval. The health provider cooperative shall file each contract between the cooperative and a purchaser with the commissioner. The commissioner shall disapprove any contract:

1. In which the consideration paid for health services is unreasonably high in relationship to the services provided.

2. That fails to include evidence of the specific procedures used to inform prospective enrollees of any limitations imposed on the enrollee's right to receive care from a health provider of the enrollee's choice.

3. Under which a health provider cooperative assumes a corridor of risk greater than fifteen percent in its first year of operation, or greater than thirty percent in any year thereafter.

Any actuarial costs incurred by the department in review of that filing must be borne by the cooperative. The commissioner may adopt rules implementing this section.

Election of directors - Vote by mail. Directors of health provider cooperatives are elected under procedures set forth in chapter 10-15. A member may vote by mail for a director unless mail voting is prohibited for election of directors by the articles or bylaws of the cooperative. The board of directors shall prescribe the form of the ballot. The members shall mark the ballot for the candidate chosen and mail the ballot to the cooperative in a sealed plain envelope inside another envelope bearing the member's name. If the ballot of the member is received by the cooperative on or before the date of the regular members' meeting, the ballot must be accepted and counted as the vote of the absent member.

State and federal governmental participation. The state or federal government, or any entity or political subdivision of the state or federal government, may be a member of a health provider cooperative. Any state or federal governmental hospital may be a member of a health provider cooperative. With respect to federal governmental participation:

1. A health provider cooperative may limit its enrollment to those persons entitled to care under the federal program responsible for the health provider cooperative.

2. A health provider cooperative may request that the commissioner waive the eligibility requirements for participation that are contrary to federal law or regulations.

3. The commissioner shall consult with federal officials to develop procedures to allow a health provider cooperative to use the federal government as a guaranteeing organization.

4. In developing and implementing initiatives to expand access to health care, the commissioner must recognize the unique problems of veterans and consider methods to reach underserved portions of the veteran population.

Prohibited practices - Penalty.

1. It is unlawful for any person, company, or corporation or any agent, officer, or employee thereof, to coerce or require any person to agree, either in writing or orally, not to join or become or remain a member of any health provider cooperative as a condition of securing or retaining a contract for health care services with the person, firm, or corporation.

2. It is unlawful for any person, company, or corporation, or any combination of persons, companies, or corporations, or any agents, officers, or employees thereof, to engage in acts of coercion, intimidation, or boycott of, or any refusal to deal with, any health care providing entity arising from that entity's actual or potential participation in a health provider cooperative.

3. It is unlawful for any health provider cooperative to engage in any acts of coercion, intimidation, or boycott of, or any concerted refusal to deal with any health plan company seeking to contract with the cooperative on a competitive, reasonable, and nonexclusive basis.

4. It is unlawful for any health provider cooperative to refuse membership to any licensed health care provider or organization that applies for membership and that otherwise agrees to the membership requirements of the health provider cooperative.

5. Any person violating subsections 1 through 4 is deemed to have committed a violation of chapter 51-08.1 and is subject to the provisions, procedures, and penalties of that chapter.

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