PROPOSED RULES

NORTH DAKOTA ADMINISTRATIVE CODE
CHAPTER 45-03-15
ACCOUNTING PRACTICES AND PROCEDURES

Sections 45-03-15-01 and 45-03-15-02 are amended as follows:

45-03-15-01. Accounting practices and procedures. Every insurance company doing business in this state shall file with the commissioner, pursuant to North Dakota Century Code section 26.1-03-07, the appropriate national association of insurance commissioners annual statement blank, prepared in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March ~~2011~~ 2013 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; , 2013.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-03-07, 26.1-03-11.1

45-03-15-02. Reporting of financial information. Every insurance company licensed to do business in this state shall transmit to the commissioner and to the national association of insurance commissioners its most recent financial statements compiled on a quarterly basis, within forty-five days following the calendar quarters ending March thirty-first, June thirtieth, and September thirtieth. The financial statements must be prepared and filed in the form prescribed by the commissioner and in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March ~~2011~~ 2013 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance. The commissioner may exempt any company or category or class of companies from the filing requirement.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; , 2013.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-03, 26.1-03-07, 26.1-03-11.1

PROPOSED RULES

NORTH DAKOTA ADMINISTRATIVE CODE
CHAPTER 45-03-24
UNCLAIMED LIFE INSURANCE BENEFITS

Chapter 45-03-24 is created as follows:

45-03-24-01. Commissioner's authority. Pursuant to North Dakota Century Code chapter 26.1-55, the commissioner may approve a transition plan and timeline temporarily waiving some or all of the requirements of chapter 26.1-55 to allow insurance companies to phase into compliance with chapter 26.1-55.

History: Effective _____.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-55

45-03-24-02. Applicability. Companies failing to receive transition plan approval or failing to meet a timeline approved by the commissioner must comply with North Dakota Century Code chapter 26.1-55.

History: Effective _____.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-55

45-03-24-03. Requirements. The Commissioner may approve a transition plan temporarily waiving some or all of the requirements of North Dakota Century Code chapter 26.1-55 if:

a. The commissioner determines that policyholders would be harmed in the absence of a waiver.

b. The insurance company transition plan is submitted to the commissioner at least six months prior to the waiver date requested.

c. The transition plan includes a timeline to convert electronic records and implement electronic searches within a reasonable time as determined by the commissioner.

History: Effective _____.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-55

10/29/13

PROPOSED RULES

NORTH DAKOTA ADMINISTRATIVE CODE
CHAPTER 45-06-15
SHORT-TERM CARE INSURANCE

Chapter 45-06-15 is created as follows:

45-06-15-01. Definition. "Short-term care insurance" means any insurance policy, group certificate or rider primarily advertised, marketed, offered, or designed to provide coverage for less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Service settings may include a hospital unit licensed or certified to provide skilled nursing services in a skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, basic care facility, personal care facility, adult day care facility, and assisted living facility. The term also includes home health care and personal care services provided by a home health care agency. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as short-term care insurance is subject to the provisions of this chapter.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-02. Policy definitions. No short-term care insurance policy or group certificate delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

3. "Adult day care" means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

4. "Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

5. "Certificate" or "Group Certificate" means the insurance document or certificate of insurance coverage issued to individuals covered under the group policy.

6. "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

7. "Continence" means the ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

8. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

9. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table or by a feeding tube or intravenously.

10. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

11. "Home health care services" means medical and nonmedical services

provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

12. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended" or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as The Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

13. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

14. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

15. "Skilled nursing care", "intermediate care", "personal care", "home care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

16. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

17. "Transferring" means moving into or out of a bed, chair, or wheelchair.

18. All providers of services, including "skilled nursing facility", "extended care facility", "intermediate care facility", "convalescent nursing home", "personal care facility", and "home care agency", shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-03. Policy practices and provisions.

1. **Guaranteed renewable for life – Limitation on preexisting conditions.** Any short-term care insurance policy or group certificate must be guaranteed renewable for life. For purposes of this section, "guaranteed renewable for life" means the insured has the right to continue the policy or group certificate for life subject to the policy's terms by the timely payment of premiums during which the insurer has no right to make

unilaterally any change in any provision of the policy while the policy is in force. The insurer may, however, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who are placed in the same class for purposes of rate determination in the process of issuance of the policy or group certificate.

A policy or certificate of insurance, providing benefits for short term care, which is sold to a consumer to replace a policy may not contain any provision limiting payment of benefits due to preexisting conditions of the insured except if there is any time period remaining relating to the exclusion of coverage for preexisting conditions as specified in the underlying policy that the remaining waiting period for coverage of preexisting conditions shall apply to the new policy unless the policy otherwise provides.

2. **Preexisting conditions.**

a. No short-term care insurance policy or group certificate may define "preexisting condition" as more restrictive than meaning a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

b. No short-term care insurance policy or certificate issued on a group short-term care insurance policy may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

c. The limitation on defining a preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision b expires. No short-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision b.

3. **Required information and disclosure provisions.**

a. Limitations. If a short-term nursing home insurance policy or group certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of

the policy or certificate and shall be labeled as "preexisting condition limitations."

b. Other limitations or conditions on eligibility for benefits. A short-term nursing home insurance policy or group certificate containing any limitations or conditions for eligibility including any elimination period shall be clearly defined in the policy or certificate and shall be labeled as "limitations or conditions on eligibility for benefits."

c. Insurers shall disclose whether or not inflation protection is offered with any short-term nursing home policy or group certificate.

d. An elimination period shall be calculated based upon consecutive calendar days, beginning the first day eligible services are received by the individual and ending the first day benefits are payable.

4. **Incontestability and rescission of short-term care insurance policy or certificate.**

a. If a policy or certificate has been in force for less than six months, an insurer may not rescind a short-term care insurance policy or certificate or deny an otherwise valid short-term care insurance claim except upon a showing of misrepresentation that is material to the acceptance for coverage.

b. If a policy or certificate has been in force for at least six months but less than two years, an insurer may not rescind a short-term care insurance policy or certificate or deny an otherwise valid short-term care insurance claim except upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.

c. If a policy or certificate has been in force for two years, the policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health. The policy or certificate may not be contested based upon misrepresentation alone.

d. A short-term care insurance policy or certificate may not be field-issued based on medical or health status. For purposes of this section, "field-issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

e. If an insurer has paid benefits under the short-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

5. **Prior institutionalization requirement prohibited.**

a. No short-term care insurance policy or certificate may be delivered or issued for delivery in this state if the policy:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement.

(2) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of such institutional care.

b. A short-term care insurance policy containing postconfinement, postacute care, or recuperative benefits must clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" the limitations or conditions, including any required number of days of confinement.

6. **Right to return policy.** Short-term care insurance applicants have the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Short-term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate the applicant is not satisfied for any reason.

7. **Limitations and exclusions.** A policy may not be delivered or issued for delivery in this state as short-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

a. Preexisting conditions or diseases;

b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease;

c. Alcoholism and drug addiction;

d. Illness, treatment, or medical condition arising out of:

(1) War or act of war, whether declared or undeclared;

(2) Participation in a felony, riot, or insurrection;

(3) Service in the armed forces or units auxiliary thereto;

(4) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(5) Aviation (this exclusion applies only to non-fare-paying passengers).

e. Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under medicare or other governmental program, except medicaid, any state or federal workers compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.

This subsection is not intended to prohibit exclusions limitations by type of provider or territorial limitations.

8. **Extension of benefits.** Termination of short-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the short-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the short-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

9. **Continuation or conversion.**

a. Group short-term nursing home insurance issued in this state on or after the effective date of this administrative regulation shall provide:

(1) A covered individual with a basis for continuation or conversion of coverage without underwriting upon termination of coverage; and

(2) A converted policy or continued coverage including benefits identical to or benefits determined by the executive director to be substantially similar to or in excess of those provided under the group policy from which conversion or continued coverage is made.

b. Written application for the converted policy or continued coverage

shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days following notice of continuation or conversion rights under the group policy.

c. The premium charged to an insured for short-term nursing home insurance shall not increase due to either:

(1) The increasing age of the insured at ages beyond sixty-five; or

(2) The duration the insured has been covered under the policy.

10. **Discontinuance and replacement.** If a group short-term care policy is replaced by another group short-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of short-term care services.

c. The premium charged to an insured shall not increase due to either:

(1) The increasing age of the insured at ages beyond sixty-five; or

(2) The duration the insured has been covered under the policy.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-04. Unintentional lapse. Each insurer offering short-term care insurance shall, as a protection against unintentional lapse, comply with the following:

1. a. Notice before lapse or termination. No individual short-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant

electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this short-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

b. When the policyholder or certificate holder pays premium for a short-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision a need not be met until sixty days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

c. Lapse or termination for nonpayment of premium. No individual short-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subdivision a, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, and notice may not be given until thirty days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

2. Reinstatement. In addition to the requirement in subsection 1, a short-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past-due premium, when appropriate. The standard of

proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-05. Payment of benefits. A short-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-06. Required disclosure of rating practices to consumers.

1. A statement that the policy may be subject to rate increases in the future.

2. If a short-term care policy uses gender rating to determine the policy's premium rate, the short-term care policy must contain the following language in conspicuous font on the application, on the outline of coverage provided to the consumer at the time of solicitation, and on the front page of the insurance policy/certificate:

   > The cost for this product is based in part upon the gender of the person being insured. Buying this product means you agree to allow [insert Company or Agency Name Here] to determine the cost of this product based in part upon the gender of the person being insured.

   The individual or individuals purchasing a short-term care insurance policy using gender rating to determine a policy's premium rate must specifically sign, initial or otherwise acknowledge the gender rating provision detailed above on the application. A copy of the acknowledged application must be retained by the insurance company selling the policy.

3. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by this section when the rate increase is implemented.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-07. Prohibition against post-claims underwriting.

1. a. If an application for short-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list all medication that has been prescribed.

   b. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

2. The following language, or language substantially similar to the following, shall be set out conspicuously on the short-term care insurance policy or certificate no later than when it is delivered:

   "Caution: The issuance of this short-term care insurance (policy or certificate) is based upon your responses to the questions on your application. A copy of your (application or enrollment form) (is enclosed or was retained by you when you applied). If your answers, to the best of your knowledge and belief, are incorrect or untrue, the insurer may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address)."

3. A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than when the policy or certificate is delivered unless it was retained by the applicant at the time of application.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-08. Requirements for application forms and replacement coverage.

1. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a short-term care insurance policy or certificate:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

2. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another short-term care or long-term care insurance policy or certificate in force or whether a short-term care policy or certificate is intended to replace any other accident and sickness or short-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except when the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or short-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

   a. Do you have another short-term care or long-term insurance policy or certificate in force, including health care service contract, health maintenance organization contract?

   b. Did you have another short-term care or long-term care insurance policy or certificate in force during the last twelve months?

      (1) If so, with which company?

      (2) If that policy lapsed, when did it lapse?

   c. Are you covered by medicaid?

   d. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

3. Agents shall list any other health insurance policies they have sold to the applicant.

   a. List policies sold that are still in force.

   b. List policies sold in the past five years that are no longer in force.

4. Replacements - Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of the individual short-term care insurance policy, a notice regarding replacement of accident and sickness or short-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be

retained by the insurer. The required notice shall be provided as referenced in Appendix A.

5. Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness, short term or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided as referenced in Appendix B.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-09. Loss ratio. Benefits under short-term care insurance policies must be deemed reasonable in relation to premiums provided the expected loss ratio is at least seventy percent, calculated in a manner which provides for adequate reserving of the insurance risk. In evaluating the expected loss ratio, due consideration must be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments, or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Policy reserves;
11. Mix of business by risk classification; and
12. Product features such as elimination periods, deductibles, and maximum limits.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-10. Filing requirements for advertising.

1. Every insurer, health care service plan, or other entity providing short-term care insurance or benefits in this state shall provide a copy of any short-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the insurance commissioner of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

2. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-11. Standards for marketing.

1. Display prominently on the first page of the outline of coverage and policy the following:

   "Notice to buyer: This policy may not cover all of the costs associated with short-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

2. A short-term care policy shall state in on the front page of the policy and outline of coverage the following statement:

   "This is a Short-Term care policy that offers benefits for less than twelve (12) months. This is not a Long-Term care policy."

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-12. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a short-term care insurance policy or certificate replaces another short-term or long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new short-term care policy for similar benefits to the extent

that similar exclusions have been satisfied under the original policy.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-13. Standards for benefit triggers.

1. A short-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

2. a. Activities of daily living shall include at least the following:

   (1) Bathing;

   (2) Continence;

   (3) Dressing;

   (4) Eating;

   (5) Toileting; and

   (6) Transferring.

   b. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subdivision a as long as they are defined in the policy.

3. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections 1 and 2.

4. For purposes of this section, the determination of a deficiency shall not be more restrictive than:

   a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

   b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

5. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

6. Short-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

45-06-15-14. Standard format outline of coverage.

1. The outline of coverage shall be a freestanding document, using no smaller than ten-point type.

2. The outline of coverage shall contain no material of an advertising nature.

3. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

4. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

5. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY AND STATE]

[TELEPHONE NUMBER]

SHORT-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this short-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers

are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. Terms Under Which the Policy OR Certificate May Be Continued in Force or Discontinued.

   a. [For short-term care health insurance policies or certificates describe the following permissible policy renewability provisions: Policies and certificates that are guaranteed renewable shall contain the following statement: RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.]

   b. [For group coverage, specifically continuation/conversion provisions applicable certificate and group policy.]

   c. [Describe waiver of premium provisions or state that there are not such provisions.]

4. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

   [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

5. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE

RETURNED AND PREMIUM REFUNDED.

a. Provide a brief description of the right to return - "free look" provision of the policy.]

b. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

a. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

b. [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

7. SHORT-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered short-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

8. BENEFITS PROVIDED BY THIS POLICY.

a. [Covered services, related deductibles, waiting periods, elimination periods, and benefit maximums.]

b. [Institutional benefits, by skill level.]

c. [Noninstitutional benefits, by skill level.]

d. Eligibility for Payment of Benefits.

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for short-term care and must be defined and described as part of the outline of coverage.]

e. [Any additional benefit triggers must also be explained. If these

triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

9. LIMITATIONS AND EXCLUSIONS.

[Describe:

a. Preexisting conditions;

b. Noneligible facilities and provider;

c. Noneligible levels of care (e.g., unlicensed providers, care, or treatment provided by a family member, etc.);

d. Exclusions and exceptions; and

e. Limitations.].

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR SHORT-TERM CARE NEEDS.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[a. State the total annual premium for the policy; and

b. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[a. Indicate if medical underwriting is used; and

b. Describe other important features.]

13. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING SHORT-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR SHORT-TERM CARE INSURANCE POLICY OR CERTIFICATE.

History: Effective _____, 2014.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-36-48

Appendix A

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS, SHORT TERM OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness, short term or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness, short term or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing short term or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its

agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker, or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

(Applicant's Signature) (Date)

Appendix B

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS, SHORT TERM OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness, short term or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness, short term or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing short term or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an

otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

10/29/13

PROPOSED RULES

NORTH DAKOTA ADMINISTRATIVE CODE
CHAPTER 45-10-02
PETROLEUM TANK RELEASE COMPENSATION FUND
GENERAL PROVISIONS

Chapter 45-10-02 is amended as follows:

45-10-02-01. Definitions. For the purposes of this chapter, the following definitions apply in addition to the definitions set forth in ~~section 2 of chapter 299 of the 1991 Session Laws~~ North Dakota Century Code chapter 23-37:

1. "Antifreeze" is not a petroleum product.

2. "Farm tank" means a tank located on a tract of land devoted to the production of crops or for raising animals and associated residences and improvements. A farm tank must be located on the farm property.

3. "Portable tank" means any storage tank, along with its piping and wiring, that is not stationary or affixed including, but not limited to, tanks which are on skids.

4. "Residential tank" means a tank located on property used primarily for dwelling purposes.

5. "Surface impoundment" means a natural topographic depression, manmade excavation, or diked area formed primarily of earthen materials.

6. Storage tanks used for collecting crude oil are considered flowthrough process tanks and are excluded from coverage.

History: Effective November 25, 1991; amended effective June 1, 1994; _____, 2013.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299~~ NDCC 23-37

45-10-02-02. Tank registration. On an annual basis (fiscal year July first through June thirtieth), the administrator will mail to all prior fund registrants and any other known petroleum tank owners and operators in North Dakota a registration letter and billing notice. The letter will explain the function of the fund and the requirement that the tank owner or operator must have all tanks owned or operated registered and all fees paid prior to a petroleum release in order to be eligible for reimbursement. In the event of a petroleum release, no payment will be made to an owner or operator of a registered tank unless the owner or operator has complied with all other state and federal regulations regarding petroleum tanks.

History: Effective November 25, 1991; amended effective June 1, 1994.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299, § 17~~ NDCC 23-37-17

45-10-02-03. Registration fee.

1. An annual registration fee is due and payable on July 1, 1991, and on July first of each successive year thereafter~~. Registration fees must be paid from April 1991,~~ or from the date a new tank was installed if it was after April 1991, to be in compliance with this section. The period of registration must run from July first to June thirtieth to coincide with the fiscal year of North Dakota.

2. No reregistration or fee modification will be made during any registration year when an owner or operator removes a tank or replaces an underground tank with an aboveground tank within a registration year. The renewal billing will reflect the tank status change. ~~However, a prorated registration fee is required for the installation of an additional tank within any registration year.~~

~~3. In the event the legislative assembly may make any alterations or modifications of the registration fee, the administrator shall prorate the annual registration fee accordingly.~~

History: Effective November 25, 1991; amended effective June 1, 1994; January 1, 2000; _____, 2013.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ 23-37-05

Law Implemented: ~~S.L. 1991, ch. 299, § 17~~ NDCC 23-37-17

45-10-02-04. Notification of release procedures. Upon receiving notice of a release ~~from the state department of health~~, the administrator shall:

1. Verify that the tank and all other tanks owned or operated by the operator are registered with the fund.

2. Record the release information in the ~~claim register~~ registration file for the location.

3. Verify that the state department of health has received notice of the release.

4. If the owner or operator has not registered all of the tanks owned ~~or~~ and operated by the operator at the location of the release, send a letter of denial to the owner or operator with a ~~carbon~~ copy to the state department of health and close the file.

5. Obtain verification from the owner or operator that the affected tank, equipment, components, material or dispenser is compatible and meet state requirements for the petroleum product stored and dispensed. If not compatible, send letter of denial to the owner operator with a copy to the state department of health and close file.

~~4.~~ 6. If all tanks are registered and the affected tank, piping, fitting or dispenser is compatible, notify the owner of the fund's claim filing procedures and send the tank owner or operator the fund's tank release guidelines with an application for reimbursement.

History: Effective November 25, 1991; amended effective June 1, 1994; August 1, 2000; _____, 2013.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299, §§ 10, 19~~ NDCC 23-37-10, 23-37-19

45-10-02-05. Procedures for investigation of claims. In each release investigation, the administrator shall:

1. ~~Examine~~ Investigate the location and cause of the release.

2. Interview persons with knowledge of the release.

3. Examine records and documentation concerning the release, including documentation of the corrective action taken and expenses incurred.

4. Prepare a written report determining the validity of the claim and the ~~estimated~~ eligible cleanup ~~costs~~ expenses.

5. Complete other tasks as required.

History: Effective November 25, 1991; amended effective August 1, 2000; _____, 2013.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299, §§ 18, 20, 23~~ NDCC 23-37-18, 23-37-20, 23-37-23

45-10-02-06. Reimbursement.

1. The fund will reimburse only reasonable and necessary eligible cleanup expenses as determined by the administrator in consultation with the state department of health and only if all tanks are properly registered prior to the discovery of the release.

2. No payment will be made from the fund unless a completed application form has been received by the administrator. ~~The application must contain at least the following information:~~

   ~~a. Name and address of the owner, operator, or landowner.~~

   ~~b. Street or highway description of the petroleum release location.~~

   ~~c. The legal description of the release location.~~

   ~~d. The substance released.~~

   ~~e. The date the release was discovered.~~

   ~~f. Name, address, and telephone number of the contact person.~~

   ~~g. A narrative description of the release.~~

3. Eligible expenses for corrective action include the following:

   a. Labor.

   b. Testing.

   c. Use of machinery.

d. Materials and supplies.

e. Professional services.

f. Expenses incurred ~~by order~~ through direction of ~~federal,~~ state~~, or local government~~ department of health.

g. Any other expenses the administrator and the board deem to be reasonable and necessary to remedy cleanup of the release and satisfy liability to any third party.

h. Consultant fees if authorized by the ~~North Dakota~~ state department of health ~~or other federal or state agency approving the cleanup procedures~~.

4. The following will not be considered eligible expenses under this regulation:

a. The cost of replacement, repair, and maintenance of affected tanks and associated piping.

b. Pumping out of any product, including water, from any tanks which need to be removed.

c. The cost of upgrading existing affected tanks and associated piping.

d. The loss of income, profits, or petroleum product.

e. Decreased property value.

f. Bodily injuries or property damages except for injuries or damages suffered by third parties.

g. Attorney's fees.

h. Costs associated with preparing, filing, and prosecuting an application for reimbursement or assistance under this regulation.

i. The costs of making improvements to the facility beyond those that are required for corrective action, including replacing concrete, asphalt, equipment, or buildings.

j. Any cleanup costs resulting from negligence or misconduct on the part of the owner or operator.

k. Marked-up costs.

l. Costs in excess of those considered reasonable by the fund.

~~l.~~ m. Fines or penalties imposed by order of federal, state, or local government.

~~m.~~ n. Finance charges, interest charges, or late payment charges.

5. To determine what expenses are reasonable and necessary, the owner, operator, or landowner must bid the excavation and consultant work. The lowest bid that meets the requirements of the state department of health will be deemed by the fund to be the reasonable cost for that project. The bid must be submitted according to the fund's excavation and consultant worksheets. Additional work over and above the original bid will be reimbursed according to unit costs on the original bid.

6. The administrator may provide partial payments prior to the final determination of the amount of the loss, if it is determined that the cleanup is proceeding according to the proposed workplan of the state department of health for the site assessment. The payment may be made to the owner, operator, or landowner or that person's assigned representative if the appropriate assignment form is submitted to the administrator with appropriate documentation verifying that the work has been completed by the assignee.

7. All claims for payment are subject to the availability of funds in the petroleum tank release compensation fund and must be submitted no later than one year after the work has been completed to be eligible.

8. Prior to payment for any loss, the owner, operator, or landowner shall subrogate to the fund all rights, claims, and interest which the owner, operator, or landowner has or may have against any party, person, persons, property, corporation, or other entity liable for the subject loss, and shall authorize the fund to sue, compromise, or settle in the name of the owner, operator, or landowner or otherwise, all such claims. The subrogation agreement required by this section must be prescribed and produced by the administrator.

9. Reimbursement will be considered when the owner, operator, or landowner has submitted complete excavation or consultant worksheets along with legible copies of all invoices~~, providing~~ and a description of~~:~~

~~a.~~ ~~The~~ the work performed.

~~b. The party who performed the work.~~

~~c. The location where the work was performed.~~

~~d. The date the work was performed.~~

~~e. The unit cost.~~

~~f. The total.~~

10. The owner, operator, or landowner must submit, prior to any payment, evidence that the amounts shown on the invoices for which the payment is requested were either paid in full by the owner, operator, or landowner or, if the owner, operator, or landowner has assigned the right to receive payment from the fund, that a contractor hired has expended time and materials for which payment must be made. This must include documentation that the work has been completed by the assignee.

11. Prior to payment, the administrator must be satisfied that the corrective action taken has met all state~~, federal, and local laws or~~ regulations and that the corrective action has satisfied public health, welfare, and environmental concerns.

History: Effective November 25, 1991; amended effective June 1, 1994; August 1, 2000; December 1, 2001; _____, 2013.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ NDCC 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299, §§ 18, 20, 23, 24~~ NDCC 23-37-18, 23-37-20, 23-37-23, 23-37-24

45-10-02-06.1. Reimbursement disputes. If the fund administrator denies or reduces payment to a tank owner, operator, or landowner, the tank owner, operator, or landowner may request a review by the board by filing a written request and supporting documentation with both the administrator and the board within thirty days of receiving a proof of loss. The board shall issue a written decision concerning the issues in dispute within thirty days of receiving the written notice and supporting documentation. If after review by the board a dispute still exists, the claimant or the administrator may appeal the board decision to the commissioner. The decision of the commissioner may be appealed under North Dakota Century Code chapter 28-32.

History: Effective August 1,2000; amended effective December 1, 2001.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ NDCC 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299~~ NDCC 23-37

45-10-02-07. Third-party damages. No reimbursement may be made for damage to employees as defined by the North Dakota Workers' Compensation Act or agents of the owner or operator.

History: Effective November 25, 1991.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ NDCC 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299, §§ 26, 27~~ NDCC 23-37-26, 23-37-27

45-10-02-08. Board. The administrator shall advise the board of the fund's general operations and review claims either through written correspondence, telephone conference calls, or meetings. The board shall meet at least once each half of each calendar year.

History: Effective November 25, 1991; amended effective August 1, 2000; December 1, 2001.
General Authority: NDCC 28-32-02; ~~S.L. 1991, ch. 299, § 5~~ NDCC 23-37-05
Law Implemented: ~~S.L. 1991, ch. 299, § 3~~ NDCC 23-37-03

45-10-02-09. Report to legislative assembly and governor. ~~This report, as required by section 29 of chapter 299 of the 1991 North Dakota Session Laws, must include, but is not limited to, the following information:~~

~~1. Total number of releases.~~

~~2. Total number of releases denied because of nonregistered tanks.~~

~~3. Total number of releases denied because of expenses not exceeding five thousand dollars.~~

~~4. Total number of releases investigated by the fund.~~

~~5. Total amount paid out for releases and the average payout per release.~~

~~6. Brief summary of the fund's operating expenses.~~

~~7. Recommended changes, if any, to 1991 House Bill No. 1439.~~

~~8. Recommendation to continue or terminate the program.~~

~~**History:** Effective November 25, 1991.~~
~~**General Authority:** NDCC 28-32-02; S.L. 1991, ch. 299, § 5~~
~~**Law Implemented:** S.L. 1991, ch. 299, § 29~~

Repealed effective _____, 2013.