INSURANCE

CHAPTER 251

SENATE BILL NO. 2180

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

INSURANCE PENALTIES, DECLINATION, AND ORDERS

AN ACT to create and enact sections 26.1-01-03.3 and 26.1-30.1-01.1 of the North Dakota Century Code, relating to penalty for violation of the insurance code and unlawful grounds for declination of commercial insurance; to amend and reenact sections 26.1-01-03.1, 26.1-03-17, subsection 7 of section 26.1-04-03, sections 26.1-23-06, 26.1-33-02.1, subsection 6 of section 26.1-33-30, subsection 1 of section 26.1-36-03, subsection 11 of section 26.1-36-05, subsection 6 of section 26.1-36-14, subsection 1 of section 26.1-36-23.1, and section 26.1-45-05.1 of the North Dakota Century Code, relating to cease and desist orders, premium taxes, unfair discrimination, unsatisfied judgment fund, free-look periods of life insurance policies, life insurance, accident and health insurance, and long-term care insurance; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-01-03.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-03.1. Cease and desist authority - Hearing - Failure to appear. The commissioner may issue an order to cease and desist and notice of opportunity for hearing when it appears that any person is engaged in an act or practice which violates or may lead to a violation of this title. Any party aggrieved by the commissioner's order may make written application for a hearing on the order within thirty days of the date of the order. The application for a hearing must briefly state the respects in which the applicant is aggrieved by the order and the grounds for relief to be relied upon at the hearing. A hearing must be held not later than ten days after an application for hearing is received unless a delay is requested by all persons named in the order. The commissioner, within thirty days after the hearing, shall issue an order vacating the cease and desist order or making the cease and desist order permanent, as the facts require. The failure of any named person to appear at any proper hearing under this section after receiving notice of the hearing will cause that person to be in default and the allegations contained in the cease and desist order may be deemed to be true and may be used against the person at the hearing. ~~If no civil monetary penalty is otherwise provided by law, the offender is, after hearing by the commissioner, subject to payment of an administrative monetary penalty of up to ten thousand dollars.~~ If no hearing is requested by written application, the commissioner's order becomes permanent.

SECTION 2. Section 26.1-01-03.3 of the North Dakota Century Code is created and enacted as follows:

26.1-01-03.3. Penalty for violation of title. Unless otherwise provided by law, a person who violates this title is subject, after hearing by the commissioner, to payment of an administrative monetary penalty of up to ten thousand dollars.

SECTION 3. AMENDMENT. Section 26.1-03-17 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-03-17. Commissioner to collect premium tax - Insurance companies generally - Computation - Credits - Penalty - Estimated tax.

1. Before issuing the annual certificate required by law, the commissioner shall collect from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except ~~a~~ fraternal benefit ~~society~~ and benevolent societies, doing business in this state, a tax on the gross amount of premiums, assessments, membership fees, subscriber fees, policy fees, service fees collected by any third-party administrator providing administrative services to a group that is self-insured for health care benefits, and finance and service charges received in this state during the preceding calendar year, at the rate of two percent with respect to life insurance, one and three-fourths percent with respect to accident and health insurance, and one and three-fourths percent with respect to all other lines of insurance. This tax does not apply to considerations for annuities. The total tax is payable on or before March first following the year for which the tax is assessable. Collections from this tax must be deposited in the insurance tax distribution fund under section 18-04-04.1 but not in an amount exceeding one-half of the biennial amount appropriated for distribution under section 18-04-05 in any fiscal year. Collections from this tax exceeding the amount deposited in the insurance tax distribution fund each fiscal year must be deposited in the general fund in the state treasury. If the due date falls on a Saturday or legal holiday, the tax is payable on the next succeeding business day.

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 4 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and ~~26.1-18-27~~ 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

3. Any ~~person~~ company failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of ~~five percent of the amount of tax due or~~ one hundred dollars~~, whichever is greater,~~ plus i~~nterest of one percent per month on the unpaid tax for each month or fraction of a month of delay~~ twenty-five dollars per day, excepting the

first day after the tax became due~~,~~ ~~or~~ t~~wenty-five~~ ~~dollars~~ ~~per~~ ~~day,~~ ~~whichever~~ ~~is~~ ~~greater~~. Any ~~person~~ company failing to file the appropriate tax statement required by rule if the tax is zero is subject to a penalty of twenty-five dollars per day for each day's neglect not to exceed five hundred dollars. The commissioner, if satisfied that the delay was excusable, may waive, and if paid, issue a premium tax credit for all or any part of the penalty and interest.

4. Every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except ~~a~~ fraternal benefit ~~society~~ or benevolent societies, doing business in this state required to pay premium taxes in this state shall make and file a statement of estimated premium taxes. The statement and payment must be made on a quarterly basis as prescribed by the commissioner. Failure of a company to make payments of at least one-fourth of ~~either~~ the total tax paid during the previous calendar year, or eighty percent of the actual tax for the quarter being reported of the current calendar year, shall subject the company to the penalty and interest provided in subsection 3.

5. If an amount of tax, penalty, or interest has been paid which was not due under the provisions of this section, a refund may be issued to the taxpayer who made the erroneous payment. The refund is allowed as a credit against any tax due or to become due under this section or as a cash refund, at the discretion of the commissioner. The taxpayer who made the erroneous payment shall present a claim for refund to the commissioner not later than two years after the due date of the return for the period for which the erroneous payment was made.

6. In lieu of the tax required by subsection 1, the commissioner shall collect from each entity subject to this section an annual filing fee in the amount of two hundred dollars, provided the total tax liability of the entity pursuant to subsection 1 is less than two hundred dollars. No annual filing fee is due or may be collected from an entity if its total tax liability pursuant to subsection 1 is in excess of two hundred dollars. The annual filing fee may be reduced by any credits available pursuant to subsections 2 and 5. Failure of a company to pay the two hundred dollar filing fee subjects the company to the penalty as provided in subsection 3.

[180] **SECTION 4. AMENDMENT.** Subsection 7 of section 26.1-04-03 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

7. Unfair discrimination.

   a. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the

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[180] Section 26.1-04-03 was also amended by section 1 of Senate Bill No. 2400, chapter 257, and section 2 of Senate Bill No. 2400, chapter 257.

dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

b. Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

c. Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life insurance, accident and sickness insurance, health services, or health care protection insurance available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses the insured's eyesight; however, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons.

d. Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless the action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

SECTION 5. AMENDMENT. Section 26.1-23-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-23-06. Attorney general may appear. Section 26.1-23-04 does not apply in the case of any judgment entered by default, unless the commissioner and the attorney general have been given at least thirty days' notice prior to ~~the entry of judgment~~ hearing, to which notice shall be attached a copy of the summons and complaint. Upon receipt of the notice, the attorney general may enter an appearance, file a defense, appear by counsel at the trial, or take any other action the attorney general deems appropriate on behalf of the fund and in the name of the defendant, and may thereupon, on behalf of the fund and in the name of the defendant, conduct a defense, and all acts done in accordance therewith shall be deemed to be acts of the defendant. The attorney general may appear and be heard on any application for payment from the fund and may show cause, if any, why the order applied for should not be made.

SECTION 6. Section 26.1-30.1-01.1 of the North Dakota Century Code is created and enacted as follows:

26.1-30.1-01.1. Unlawful grounds for declination. The declination or termination of a commercial insurance policy subject to sections 26.1-30.1-01 through 26.1-30.1-08 by an insurer, agent, or broker is prohibited if the declination or termination is based solely upon any of the following reasons:

1. The race, religion, nationality, ethnic group, disability, age, sex, or marital status of the applicant or named insured, except this subsection does not prohibit rating differentials based upon age, sex, or marital status.

2. The lawful occupation or profession of the applicant or named insured, except that this provision does not apply to an insurer, agent, or broker that limits its market to one lawful occupation or profession or to several related occupations or professions.

3. The age or location of the property of the applicant or named insured, unless the decision is for a business purpose that is not a mere pretext for unfair discrimination.

4. The principal location of the insured motor vehicle, unless the decision is for a business purpose which is not a mere pretext for unfair discrimination.

5. The fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

6. The fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism or an insurance company that insures substandard risks.

SECTION 7. AMENDMENT. Section 26.1-33-02.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-33-02.1. Life insurance policies and certificates - Right to return ~~policy~~. A person who purchases a life insurance policy or certificate issued or delivered in this state may return the policy or certificate within twenty days of delivery to the purchaser. If a policy or certificate is returned, the purchaser is entitled to a refund of the premium. Every life insurance policy or certificate issued or delivered in this state to any person must have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the purchaser may return the policy or certificate within twenty days of its delivery and have the premium refunded if, after examination of the policy, the applicant is not satisfied for any reason.

SECTION 8. AMENDMENT. Subsection 6 of section 26.1-33-30 of the North Dakota Century Code is amended and reenacted as follows:

6. Filings subject to this section must ~~be accompanied by a certificate signed by an officer of the life insurance company or fraternal benefit society stating that it meets~~ provide the minimum reading ease score ~~on the test used~~ or ~~stating~~ a statement that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any ~~certification~~ statement, the commissioner may require the submission of further information to verify the certification in question.

SECTION 9. AMENDMENT. Subsection 1 of section 26.1-36-03 of the North Dakota Century Code is amended and reenacted as follows:

1. No accident and health insurance policy may be delivered or issued for delivery to any person in this state unless:

   a. The entire money and other considerations for the policy are expressed in the policy.

   b. The time at which the insurance takes effect and terminates is expressed in the policy.

   c. The policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is deemed the policyholder, any two or more eligible members of that family, including spouse, dependent children or any children under a specified age which may not exceed ~~nineteen~~ twenty-two years, and any other person dependent upon the policyholder.

   d. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which is uniform and not less than ten point with a lowercase unspaced alphabet length not less than one hundred twenty point. The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

   e. The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 26.1-36-04, are printed at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". If an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

   f. Each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page thereof.

   g. It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

SECTION 10. AMENDMENT. Subsection 11 of section 26.1-36-05 of the North Dakota Century Code is amended and reenacted as follows:

11. A provision that all benefits payable under the policy or contract other than benefits for loss of time or unless subject to section 26.1-36-37.1

will be payable not more than sixty days after receipt of ~~proof, and that, subject to~~ due proof of loss~~, all~~. All accrued benefits payable under the policy or contract for loss of time will be paid at least monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of that period will be paid as soon as possible after receipt of proof of loss.

SECTION 11. AMENDMENT. Subsection 6 of section 26.1-36-14 of the North Dakota Century Code is amended and reenacted as follows:

6. Filings subject to this section must ~~be accompanied by a certificate signed by an officer of the insurance company, nonprofit health service corporation, fraternal benefit society, or health maintenance organization stating that it meets~~ provide the minimum reading ease score ~~on the test used~~ or ~~stating~~ a statement that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any ~~certification~~ statement, the commissioner may require the submission of further information to verify the certification in question.

SECTION 12. AMENDMENT. Subsection 1 of section 26.1-36-23.1 of the North Dakota Century Code is amended and reenacted as follows:

1. No group accident and health insurance policy, including a policy issued under a self-insured plan, group health service contract issued under chapter 26.1-17, or evidence of coverage issued under chapter ~~26.1-18~~ 26.1-18.1, providing coverage for hospital or medical expenses, delivered, issued for delivery, renewed, or amended after July 1, 1987, which in addition to covering the insured also provides coverage to the spouse of the insured, may contain a provision for termination of coverage for a spouse covered under the policy, contract, or evidence of coverage solely as a result of a break in the marital relationship except by reason of an entry of a decree of annulment of marriage or divorce.

SECTION 13. AMENDMENT. Section 26.1-45-05.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-05.1. ~~Rescission~~ Incontestability and rescission of long-term care insurance policy or certificate. ~~An~~ After six months from the effective date of the policy or certificate, an insurer may not contest or rescind a long-term care insurance policy or certificate or deny a claim on the basis of representations made by an insured on the application for insurance ~~after coverage has been in effect for six months~~ except upon a showing by the insurer that the insured knowingly and intentionally misrepresented relevant facts ~~relating to the insured's health~~ on the application form.

Approved April 20, 1999
Filed April 20, 1999

CHAPTER 252

SENATE BILL NO. 2181

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

INSURANCE FEES AND PENALTIES

AN ACT to amend and reenact sections 26.1-01-07, 26.1-11-06, 26.1-11-07, 26.1-26-01, 26.1-26-02, 26.1-26-03, 26.1-26-04, 26.1-26-05, 26.1-26-06, 26.1-26-08, 26.1-26-09, 26.1-26-10, 26.1-26-13, 26.1-26-14, 26.1-26-20, 26.1-26-21, 26.1-26-22, 26.1-26-23, 26.1-26-24, 26.1-26-25, 26.1-26-31, 26.1-26-32, 26.1-26-34, 26.1-26-37, 26.1-26-38, 26.1-26-40, 26.1-26-41, 26.1-26-42, 26.1-26-46, and 26.1-39-09.2 of the North Dakota Century Code, relating to fees charged by commissioner, reciprocal penalties of foreign insurance companies, countersignature requirements, and insurance agents; and to repeal sections 26.1-26-47 and 26.1-39-09.1 of the North Dakota Century Code, relating to insurance agents and property and casualty insurance programs.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

26.1-01-07. Fees chargeable by commissioner. The commissioner shall charge and collect the following fees:

1. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.

2. For each original certificate of authority issued upon admittance, one hundred dollars and for renewal of certificate of authority, amendment to certificate of authority, or certified copy thereof, fifty dollars.

3. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

4. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, twenty-five dollars.

5. For filing bylaws or amendments thereof, ten dollars.

6. For filing of articles of merger, or copies thereof, thirty dollars.

7. For receiving the service of process as attorney, whether the commissioner is served with the process or admits service thereon, ten dollars.

8. For filing of power of attorney by nonadmitted insurer for conduct of business in compliance with surplus lines laws of this state, ten dollars.

9. For filing an annual statement, twenty-five dollars.

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

11. For an official examination, the expenses of the examination at the rate adopted by the department. The rates must be reasonably related to the direct and indirect costs of the examination, including actual travel expenses, including hotel and other living expenses, compensation of the examiner and other persons making the examination, and necessary attendant administrative costs of the department directly related to the examination and must be paid by the examined insurer together with compensation upon presentation by the department to the insurer of a detailed account of the charges and expenses after a detailed statement has been filed by the examiner and approved by the department.

12. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits, and for any renewal of the certificate, ten dollars.

13. For a written licensee's examination administered by the office of the commissioner, with the examination not to exceed two lines of insurance at any one sitting, twenty dollars.

14. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which must be paid to the testing service.

15. For issuing and each annual renewal of ~~a~~ r~~esident~~ an insurance broker's, surplus lines insurance broker's, or insurance consultant's~~,~~ ~~health service corporation sales representative's, and prepaid legal services organization sales representative's~~ license, ~~or duplicate thereof,~~ ten dollars.

16. ~~For issuing and each annual renewal of a nonresident insurance broker's, health service corporation sales representative's, prepaid legal services organization sales representative's, and insurance consultant's license, or duplicate thereof, fifteen dollars.~~

~~17.~~ For issuing ~~a license for a resident agent or limited insurance representative of a foreign insurance company, or duplicate~~ an insurance agent's license, ~~ten~~ one hundred dollars.

~~18. For issuing a nonresident insurance agent's or limited insurance representative's license, or duplicate, ten dollars.~~

~~19.~~ 17. ~~For issuing a license for an agent or limited insurance representative of a domestic insurance company, county mutual insurance company, fraternal benefit society, or any other society, or duplicate, ten dollars.~~ For issuing a duplicate of any license or registration issued under this title, ten dollars.

~~20.~~ 18. For issuing and each annual renewal of a license to a resident agent for the attorney for a reciprocal exchange, ten dollars.

~~21.~~ 19. For filing of any miscellaneous documents or papers, including documents of admission and those filed annually upon license renewal, ten dollars each.

~~22.~~ 20. For a copy of any paper filed in the commissioner's office, twenty cents per folio.

~~23.~~ 21. For affixing the commissioner's official seal on a copy of any paper filed in the office and certifying the copy, ten dollars.

~~24.~~ 22. For each insurance company appointment and renewal of an appointment of an insurance agent ~~or limited insurance representative~~, ten dollars.

~~25.~~ 23. For each company application for admission, five hundred dollars, except applications for admission for county mutual, fraternal benefit, and surplus lines companies must be one hundred dollars.

~~26.~~ 24. For issuing a license and each annual renewal of a license to an insurance premium finance company, one hundred dollars.

~~27.~~ 25. For examining or investigating an insurance premium finance company, the actual expense and per diem incurred; but the per diem charge may not exceed fifty dollars.

~~28.~~ 26. For issuing and each annual renewal of a license to an advisory organization, ~~or duplicate thereof,~~ fifty dollars.

Nonprofit health service corporations and health maintenance organizations are subject to the same fees as any other insurance company. County mutual insurance companies and benevolent societies are liable only for the fees mentioned in subsections 2, 10, 11, ~~13, 19, 22, 23, and 24~~ 16, 19, 20, and 21.

However, the commissioner may, after public notice and hearing, increase the fees authorized by this section for any year if it is determined necessary to generate the revenue appropriated by the legislative assembly from the insurance regulatory trust fund to fund budgeted operations for the insurance department. The insurance commissioner may not implement a fee increase pursuant to this section to enhance or in any manner add funds to the legislative appropriation for the insurance department.

SECTION 2. AMENDMENT. Section 26.1-11-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-11-06. Reciprocal penalties - Retaliatory charges. Whenever the laws of any other state, or of any foreign country, or of any province or territory thereof, or when the rules of the insurance department of that state, country, province, or territory, require any insurance company, corporation, limited liability company, association, or society organized under the laws of this state~~, or of any agent thereof,~~ to deposit securities in that state, country, province, or territory for the protection of policyholders or others, or any payment for taxes, fines, penalties, certificates of authority, licenses, or fees, or the performance of any duties or acts other than and exceeding those required by the laws of this state of a like insurance company, corporation, limited liability company, association, or society~~, or the agents thereof,~~ organized under the laws of that state, country, territory, or province, while transacting business in this state, then and in every such case, an insurance

company, corporation, limited liability company, association, or society organized in that state, country, province, or territory which establishes an agency or transacts business in this state, is required to make deposits and to pay to the commissioner charges, licenses, fees, taxes, fines, or penalties in the amounts respectively, and to do all other acts which that other state, country, province, or territory, by the laws or the rules of the insurance department thereof, requires of a like insurance company, corporation, limited liability company, or society~~, or the agents thereof,~~ organized under the laws of this state when doing business in that other state, country, province, or territory. This section applies regardless of the plan of assessment or collection of premiums, contributions, or assessments adopted by the foreign company, corporation, limited liability company, association, or society.

SECTION 3. AMENDMENT. Section 26.1-11-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-11-07. Countersignature requirement - Commissions - Reciprocity. Notwithstanding any other provision of this title or policy forms to the contrary, ~~except as provided in section 26.1-39-09.1,~~ there may not be any requirement that an agent resident in this state sign or countersign an insurance policy covering a subject of insurance resident, located, or to be performed in this state. However, if the laws or rules of another state require a signature or countersignature by an agent resident in that state on an insurance policy written by a nonresident agent or nonresident broker of that state, then any insurance policy written by an agent resident of that state licensed as a nonresident agent in this state covering a subject of insurance resident, located, or to be performed in this state must be signed or countersigned in writing by an agent resident in this state. An insurance policy may not be deemed invalid because of the absence of the required signature or countersignature. If the laws or rules of another state require an agent resident in that state to retain a portion of the commission paid on a like insurance policy written, countersigned, or delivered by the agent in that state at the request of a nonresident agent or nonresident broker of that state, then the agent resident in this state who signed or countersigned an insurance policy written by a resident of that state licensed as a nonresident agent in this state covering a subject of insurance resident, located, or to be performed in this state shall retain an equal pro rata portion of any commission on the insurance policy.

[181] **SECTION 4. AMENDMENT.** Section 26.1-26-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-01. Scope. This chapter governs the qualifications and procedures for the licensing of insurance agents, insurance brokers, insurance consultants, ~~limited~~ i~~nsurance~~ r~~epresentatives,~~ and surplus lines insurance brokers. This chapter applies to all lines of insurance and types of insurers including life, health, property, liability, credit, title, fire, or marine operating on a stock, mutual, reciprocal, benevolent, fraternal, or health service plan, as set forth in this title.

SECTION 5. AMENDMENT. Section 26.1-26-02 of the North Dakota Century Code is amended and reenacted as follows:

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[181] Section 26.1-26-01 was also amended by section 8 of House Bill No. 1175, chapter 254.

26.1-26-02. Definitions. As used in this chapter, unless the context requires otherwise:

1. "Insurance" includes annuities.

2. "Insurance agent" means an individual, partnership, limited liability partnership, corporation, or limited liability company appointed by an insurer to solicit applications for an insurance policy or to negotiate a policy on its behalf.

3. "Insurance broker" means any individual, partnership, limited liability partnership, corporation, or limited liability company which, for compensation, not being a licensed agent for the insurer in which an insurance policy is placed, acts or aids in any manner in negotiating insurance contracts or placing risks of effecting insurance for a party other than oneself or itself.

4. "Insurance consultant" means an individual, partnership, limited liability partnership, corporation, or limited liability company that, for a fee, holds oneself or itself out to the public as engaged in the business of offering any advice, counsel, opinion, or service with respect to the benefits, advantages, or disadvantages promised under any insurance policy that could be issued in this state.

5. ~~"Limited insurance representative" means an individual, partnership, corporation, or limited liability company authorized by the commissioner to solicit or negotiate contracts for a particular line of insurance which the commissioner may by rule deem essential for the transaction of business in this state and which does not require the professional competency demanded for a license as an insurance agent or insurance broker.~~

~~6.~~ "Surplus lines insurance broker" means an individual, partnership, limited liability partnership, corporation, or limited liability company which solicits, negotiates, or procures an insurance policy from an insurer not licensed to transact business in this state which cannot be procured from an insurer licensed to do business in this state.

SECTION 6. AMENDMENT. Section 26.1-26-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-03. Acting as agent, broker, or consultant~~, or limited representative~~ without license prohibited - Penalty. No person may act as or hold oneself out to be an insurance agent, insurance broker, insurance consultant, ~~limited insurance representative,~~ or surplus lines insurance broker unless licensed under this chapter. No insurance agent, insurance broker, ~~limited insurance representative,~~ or surplus lines insurance broker may apply for, procure, negotiate for, or place for others, any policy for any line of insurance as to which that person is not then qualified and licensed under this chapter. ~~No insurance agent or limited insurance representative may place an insurance policy with any insurer as to which that person does not then hold a license as an insurance agent or limited insurance representative under this chapter.~~ Any person willfully violating this section is guilty of a class C felony.

SECTION 7. AMENDMENT. Section 26.1-26-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-04. Payment to or acceptance by unlicensed person of commission prohibited - When payment or assignment of commissions permitted. No insurer, insurance agent, insurance broker, ~~limited insurance representative,~~ or surplus lines 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 that person held at the time the services were performed a valid license for that line of insurance as required by the laws of this state; nor may any person, other than a person licensed by this state as an insurance agent, insurance broker, ~~limited insurance representative,~~ or surplus lines insurance broker at the time the services were performed, accept any such commission, brokerage, or other valuable consideration. In the case of an insurance agent, the agent must also be properly appointed under this chapter before the insurer may pay, or the agent may accept, any commission or other valuable consideration for services as an insurance agent. However, any person licensed under this chapter may pay or assign that person's commissions, or direct that the commissions be paid, to a partnership or limited liability partnership of which that person is a member, employee, or agent, to a corporation of which that person is an officer, employee, or agent, or to a limited liability company of which that person is a manager, employee, or agent. This section does not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto under this section.

SECTION 8. AMENDMENT. Section 26.1-26-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-05. Unlicensed person - Effect - Agent for insurer. A person not licensed as an insurance agent, insurance broker, ~~limited insurance representative,~~ or surplus lines insurance broker who solicits an insurance policy on behalf of an insurer is an insurance agent within the intent of this chapter, and is liable for all the duties, requirements, liabilities, and penalties to which an insurance agent of the insurer is subject~~, and the~~. An insurer ~~by compensating that~~ accepting business from an unlicensed person through any of its officers, agents, or employees ~~for soliciting insurance policies~~ thereby ~~accepts and~~ acknowledges that person as its agent in the transaction. A person not licensed as an insurance broker, but who solicits an insurance policy on behalf of others or transmits for others an application for an insurance policy to or from an insurer, or offers or assumes to act in the negotiations of such insurance, is an insurance broker within the intent of this chapter, and is liable for all the duties, requirements, liabilities, and penalties to which licensed brokers are subject.

SECTION 9. AMENDMENT. Section 26.1-26-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-06. ~~Agent or limited representative~~ Insurance agent - Agent of insurer. Every insurance agent ~~or limited insurance representative~~ who solicits or negotiates an application for insurance of any kind is, in any controversy between the insured or the insured's beneficiary and the insurer, regarded as representing the insurer and not the insured or the insured's beneficiary. This section does not affect the apparent authority of an agent.

SECTION 10. AMENDMENT. Section 26.1-26-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-08. Licensing of partnership, limited liability partnership, corporation, or limited liability company - Notice of change of individuals. A partnership, limited liability partnership, corporation, or limited liability company engaging in the

activities of an insurance agent, insurance broker, ~~limited~~ ~~insurance~~ ~~representative,~~ or surplus lines insurance broker must be licensed as such. Every member of the partnership or limited liability partnership, every officer, director, stockholder, and employee of the corporation, and every manager, governor, member, and employee of the limited liability company ~~personally~~ ~~engaged~~ ~~in~~ ~~this~~ ~~state~~ ~~in~~ ~~soliciting~~ ~~or~~ ~~negotiating~~ ~~policies~~ ~~of~~ ~~insurance~~ must be registered with the commissioner~~,~~ ~~and~~ ~~each~~ ~~member,~~ ~~officer,~~ ~~director,~~ ~~stockholder,~~ ~~manager,~~ ~~governor,~~ ~~or~~ ~~employee~~ ~~must~~ ~~also~~ ~~be~~ ~~licensed.~~ ~~Within~~ ~~a~~ ~~reasonable~~ ~~time~~ ~~after~~ ~~the~~ ~~transfer~~ ~~of~~ ~~ownership~~ ~~of~~ ~~a~~ ~~partnership,~~ ~~corporation,~~ ~~or~~ ~~limited~~ ~~liability~~ ~~company~~ ~~or~~ ~~after~~ ~~receipt~~ ~~of~~ ~~a~~ ~~properly~~ ~~completed~~ ~~application~~ ~~from~~ ~~a~~ ~~partnership,~~ ~~corporation,~~ ~~or~~ ~~limited~~ ~~liability~~ ~~company~~ ~~for~~ ~~a~~ ~~license~~ ~~as~~ ~~an~~ ~~insurance~~ ~~agent,~~ ~~insurance~~ ~~broker,~~ ~~limited~~ ~~insurance~~ ~~representative,~~ ~~or~~ ~~surplus~~ ~~lines~~ ~~insurance~~ ~~broker,~~ ~~the~~ ~~commissioner~~ ~~may~~ ~~conduct~~ ~~investigations~~ ~~and~~ ~~propound~~ ~~interrogatories~~ ~~to~~ ~~satisfy~~ ~~the~~ ~~commissioner~~ ~~that~~ ~~the~~ ~~owners,~~ ~~stockholders,~~ ~~partners,~~ ~~or~~ ~~members~~ ~~of~~ ~~the~~ ~~partnership,~~ ~~corporation,~~ ~~or~~ ~~limited~~ ~~liability~~ ~~company~~ ~~are~~ ~~competent,~~ ~~trustworthy,~~ ~~financially~~ ~~responsible,~~ ~~and~~ ~~of~~ ~~good~~ ~~personal~~ ~~and~~ ~~business~~ ~~reputation~~. The required license fee must be paid for the partnership, limited liability partnership, corporation, or limited liability company ~~and~~ ~~for~~ ~~each~~ ~~individual~~ ~~registered~~. The partnership, limited liability partnership, ~~corporate~~ corporation, or limited liability company licensee shall within ten business days notify the commissioner of every change relative to the individuals registered under the partnership, corporation, or limited liability company. This section does not apply to a management association, partnership, limited liability partnership, corporation, or limited liability company whose operations do not entail the solicitation of insurance from the public. Every partnership or corporation subject to this section must be licensed by January 1, 1994.

SECTION 11. AMENDMENT. Section 26.1-26-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-09. Exceptions to licensing requirements. No license as an insurance agent, insurance broker, ~~limited~~ ~~insurance~~ ~~representative,~~ or surplus lines insurance broker is required of:

1. Any regular salaried officer or employee of an insurance company, licensed insurance agent, insurance broker, ~~limited~~ ~~insurance~~ ~~representative,~~ or surplus lines insurance broker if the officer's or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

2. Any person who secures and furnishes information for the purpose of group or wholesale life insurance, annuities, or group, blanket, or franchise health insurance, or for enrolling individuals under such plans or issuing certificates under such plans or otherwise assisting in administering such plans, where no commission is paid for the service.

3. Employers or their officers or employees or the trustees of any employee trust plan, to the extent that the employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company; provided, that the employers, officers, employees, or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing the insurance.

4. Employees of a creditor who enrolls debtors under a group policy; provided, that the employees receive no commission or other compensation directly related to the enrollment.

SECTION 12. AMENDMENT. Section 26.1-26-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-10. Consultant - Exceptions to licensing requirement. ~~No~~ An individual, partnership, limited liability partnership, corporation, or limited liability company may not act as an insurance consultant until licensed as such by the commissioner. However, a license as an insurance consultant is not required of:

1. An attorney licensed to practice law in this state acting in the attorney's professional capacity.

2. A licensed insurance agent, insurance broker, or surplus lines insurance broker.

3. A trust officer of a bank acting in the normal course of the trust officer's employment.

4. An actuary or a certified public accountant who provides information, recommendations, advice, or services in the actuary's or the certified public accountant's professional capacity.

SECTION 13. AMENDMENT. Section 26.1-26-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-13. ~~Agent or limited representative~~ Insurance agent - Application - Age - Appointment by insurer. Every applicant for a license as an insurance agent ~~or limited insurance representative,~~ except a partnership, limited liability partnership, corporation, or limited liability company, must be eighteen years or more of age. The application for a license as an insurance agent ~~or limited insurance representative~~ must be accompanied by a written appointment. The appointment must be made by an officer of the insurer designating the applicant as an insurance agent ~~or limited insurance representative~~ for the lines of insurance the applicant will be authorized to write for the insurer. An insurance agent ~~or limited insurance representative~~ may represent as many insurers as may appoint the agent or representative. All appointments for any licensee must be submitted on behalf of the appointing insurer, on a form prescribed by the commissioner, and unless terminated remain in force until 12:01 a.m. on the annual renewal date. An insurer accepting business from unappointed agents with a frequency indicating a general business practice will be deemed to have violated this section. An insurance agent who holds a valid license may solicit applications for insurance on behalf of an admitted insurer with which the insurance agent does not have a valid appointment on file with the commissioner if the insurance agent has permission from the insurer to solicit insurance on the insurer's behalf and if the insurer upon receipt of the application for insurance submits a written notice of appointment to the commissioner accompanied by the insurer's check payable in the amount of the appointment fee prescribed in subsection 24 of section 26.1-01-07. The notice of appointment must be on a form prescribed by the commissioner.

SECTION 14. AMENDMENT. Section 26.1-26-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-14. ~~Consultant~~ - Investigation by commissioner. Within a reasonable time after receipt of a properly completed application for a license ~~as an~~ i~~nsurance consultant~~ under this chapter, the commissioner may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter which the commissioner believes necessary or advisable to determine compliance with this chapter or for the protection of the public.

SECTION 15. AMENDMENT. Section 26.1-26-20 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-20. Nonresident license - Must hold like license elsewhere. An applicant may qualify for a nonresident license if the applicant holds a like resident license from a state, province of Canada, or other foreign country. A license issued to a nonresident of this state grants the same rights and privileges afforded a resident licensee~~, except as provided in section 26.1-26-47~~.

SECTION 16. AMENDMENT. Section 26.1-26-21 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-21. ~~Nonresident~~ Agents to designate commissioner as attorney for service of process - Fee. The commissioner may not issue a license to any ~~nonresident~~ applicant until the applicant files with the commissioner a designation of the commissioner and the commissioner's successors in office, as the applicant's true and lawful attorney, upon whom may be served all lawful process in any action or proceeding instituted by or on behalf of any interested person arising out of the applicant's insurance business in this state. The designation constitutes an agreement that the service of process is of the same legal force and validity as personal service of process in this state upon the person.

SECTION 17. AMENDMENT. Section 26.1-26-22 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-22. Nonresident proceeding by commissioner - Service of process - Procedure. The commissioner shall serve process upon any nonresident licensee in any action or proceeding instituted by the commissioner under this chapter by mailing the process by registered mail return receipt requested to the licensee at the licensee's last known address of record or principal place of business. Service of process under this section is complete upon mailing.

SECTION 18. AMENDMENT. Section 26.1-26-23 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-23. Examination of individuals. Except as provided in section 26.1-26-25, the commissioner shall subject each applicant for a license as an insurance agent, insurance broker, insurance consultant, ~~limited~~ i~~nsurance re~~presentative~~,~~ ~~or~~ surplus lines insurance broker, health service corporation sales representative, or prepaid legal services organization sales representative to a written examination as to competence to act as a licensee.

SECTION 19. AMENDMENT. Section 26.1-26-24 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-24. Examination when partnership, limited liability partnership, corporation, or limited liability company is applicant. If an applicant is a partnership, limited liability partnership, corporation, or limited liability company, ~~each~~ at least

one individual who is to be registered with the ~~corporate~~ corporation, partnership, limited liability partnership, or limited liability company license must be designated as the company's principal agent. The individual designated as the principal agent of the partnership, limited liability partnership, corporation, or limited liability company, shall take the examination required by 26.1-26-23. The partnership, limited liability partnership, corporation, or limited liability company, may only be initially licensed and continue to maintain a license for those lines of insurance in which one or more of its principal agents is licensed. The partnership, limited liability partnership, corporation or limited liability company, shall inform the commissioner within ten working days of any change in status of its principal agent or agents.

[182] **SECTION 20. AMENDMENT.** Section 26.1-26-25 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-25. Exceptions from examination. The requirement for a written examination is subject to the following exceptions:

1. An applicant for a license covering the same line or lines of insurance for which the applicant was licensed under a like resident license in this state, other than a temporary license, within the twelve months next preceding the date of application, unless the previous license was suspended or revoked by the commissioner.

2. A nonresident applicant may be licensed without examination if the ~~commissioner of the~~ public official having supervision of insurance in the state of the applicant's residence certifies, by facsimile signature and seal, that the applicant has passed a similar written examination, or has been a continuous holder prior to the time the written examination was required, of a license like the license being applied for in this state.

3. An applicant who has been licensed under a like license in another state within twelve months prior to the application for a license in this state, and who files with the commissioner the certificate of the public official having supervision of insurance in the other state, by facsimile signature and seal, as to the applicant's license and good standing in such state; provided, however, that the applicant shall take that portion of the examination pertaining to state laws and rules.

4. An applicant who has attained the designation of chartered life underwriter is only required to take that portion of the examination for lines one and eighteen pertaining to state laws and rules.

5. An applicant who has attained the designation of chartered property and casualty underwriter is only required to take that portion of the examination for lines two through seventeen pertaining to state laws and rules.

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[182] Section 26.1-26-25 was also amended by section 11 of House Bill No. 1175, chapter 254.

6. An applicant ~~for a license to act as a limited insurance representative~~ may be licensed without examination ~~in one or more of the following lines:~~

   ~~a. Any ticket-selling agent of a common carrier who acts thereunder only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by the common carrier, or an applicant selling limited travel accident insurance in transportation terminals.~~

   ~~b. Any other lines that~~ to market a specific product type if the commissioner finds by rule ~~do~~ the specific product type does not require the professional competency demanded for ~~a license as an agent or broker~~ other product types.

SECTION 21. AMENDMENT. Section 26.1-26-31 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-31. Term of license. A license issued under this chapter continues in force in perpetuity unless:

1. The license is suspended, revoked, or refused by the commissioner;

2. The licensee voluntarily consents to the suspension, revocation, or refusal of the license;

3. The licensee dies or in the case of a corporation, partnership, limited liability partnership, or limited liability company, the licensee is dissolved, consolidated, merged, or otherwise has ceased to exist;

4. The licensee no longer meets the residence requirements of section 26.1-26-19;

5. The insurance agent or limited insurance representative is terminated or nonrenewed by all appointing insurers;

6. The insurance broker or surplus lines insurance broker has failed to maintain a bond as required by section 26.1-26-18, has failed to maintain a resident or nonresident license as an insurance agent as required by section 26.1-26-16, or has failed to pay the annual renewal fee to the commissioner; or

7. The insurance consultant has failed to pay the annual renewal fee to the commissioner.

SECTION 22. AMENDMENT. Section 26.1-26-32 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-32. Renewal of appointments and licenses - Annual fee. An appointment of an insurance agent ~~or limited insurance representative~~ and the license of an insurance broker, surplus lines insurance broker, or insurance consultant terminates upon failure to pay the prescribed annual renewal fees before May first.

SECTION 23. AMENDMENT. Section 26.1-26-34 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-34. Termination reports by insurer - Duty of insurer - Information furnished privileged in civil action. If an appointment is terminated for any of the grounds listed in this chapter, or for cause as defined by the insurer involved, the insurer shall promptly give written notice of the termination and the effective date of the termination to the commissioner and to the licensee where reasonably possible. The commissioner may require the insurer to demonstrate that the insurer has made a reasonable effort to notify the licensee.

All notices of termination must be filed in due course on forms prescribed by the commissioner stating the grounds and circumstances of termination.

~~If the termination is for any of the grounds listed in this chapter, the insurer shall so notify the commissioner.~~ Any information, document, record, or statement provided pursuant to this section may be used by the commissioner in any action taken pursuant to sections 26.1-26-42, 26.1-26-43, and 26.1-26-50; however, the information is privileged in any civil action between the reporting insurer and the terminated licensee.

SECTION 24. AMENDMENT. Section 26.1-26-37 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-37. Lost, stolen, or destroyed license - Issuance of duplicate. ~~The~~ Upon payment of the fee for a duplicate license under section 26.1-01-07, the commissioner may issue a duplicate license for any lost, stolen, or destroyed license issued pursuant to this chapter upon an affidavit of the licensee, as prescribed by the commissioner, concerning the facts of the loss, theft, or destruction.

SECTION 25. AMENDMENT. Section 26.1-26-38 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-38. Controlled business prohibited - Definition - Formula for determination. The commissioner may not grant, renew, continue, or permit to continue any license if the commissioner finds that the license is being or will be used by the applicant or licensee for the purpose of writing controlled business. Controlled business means insurance written on the interests of the licensee, or those of the licensee's immediate family or of the licensee's employer; or insurance covering the licensee or members of the licensee's immediate family or a corporation, limited liability company, limited liability partnership, association, or partnership, or the officers, directors, substantial stockholders, partners, or employees of such a corporation, limited liability company, limited liability partnership, association, or partnership of which the licensee or a member of the licensee's immediate family is an officer, director, substantial stockholder, partner, associate, or employee. A license is deemed to have been, or intended to be, used for the purpose of writing controlled business if the commissioner finds that during any twelve-month period the aggregate commissions earned from such controlled business has exceeded twenty-five percent of the aggregate commissions earned on all business written by the licensee during the same period. This section does not apply to insurance written in connection with credit transactions.

SECTION 26. AMENDMENT. Section 26.1-26-40 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-40. Refusal of initial license - Notice - Hearing. If the commissioner refuses to issue a license to an applicant ~~not previously licensed in this state~~, the notice to the applicant as provided in section 26.1-26-39 must state that the applicant may request a hearing within thirty days from the date of issuance of the notice.

The commissioner shall hold a hearing, if requested by the applicant, within thirty days of the receipt of the request for a hearing and upon ten days' written notice to the applicant.

SECTION 27. AMENDMENT. Section 26.1-26-41 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-41. Prohibited activities by consultants. No licensed consultant may employ, be employed by, or be in partnership, limited liability partnership, or ~~in~~ ~~a~~ limited liability company with nor receive any remuneration whatsoever from any licensed insurance agent, insurance broker, ~~limited~~ ~~insurance~~ ~~representative,~~ surplus lines insurance broker, or insurer arising out of activities as a consultant. No person may concurrently hold a consultant's license and a license as an insurance agent, insurance broker, ~~limited~~ ~~insurance~~ ~~representative,~~ or surplus lines insurance broker in any line.

SECTION 28. AMENDMENT. Section 26.1-26-42 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-42. License suspension, revocation, or refusal - Grounds. The commissioner may suspend, revoke, or refuse to continue or refuse to issue any license issued under this chapter if, after notice to the licensee and hearing, the commissioner finds as to the licensee any of the following conditions:

1. A materially untrue statement in the license application.

2. An acquisition or attempt to acquire a license through misrepresentation or fraud.

3. The applicant has been found to have been cheating on an examination for an insurance license.

4. Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner at the time of issuance.

5. A conviction of an offense, as defined by section 12.1-01-04, determined by the commissioner to have a direct bearing upon a person's ability to serve the public as an insurance agent, insurance broker, insurance consultant, ~~limited~~ ~~insurance~~ ~~representative,~~ or surplus lines insurance broker, or the commissioner finds, after conviction of an offense, that the person is not sufficiently rehabilitated under section 12.1-33-02.1.

6. In the conduct of affairs under the license, the licensee has used fraudulent, coercive, or dishonest practices, or has shown oneself to be incompetent, untrustworthy, or financially irresponsible.

7. A misrepresentation of the terms of any actual or proposed insurance contract.

8. The licensee has been found to have knowingly solicited, procured, or sold unnecessary, or excessive insurance coverage to any person.

9. The licensee has forged another's name to an application for insurance.

10. An improper withholding of, misappropriating of, or converting to one's own use any moneys belonging to policyholders, insurers, beneficiaries, or others received in the course of one's insurance business.

11. The licensee has been found guilty of any unfair trade practice defined in this title or fraud.

12. A violation of or noncompliance with any insurance laws of this state or a violation of or noncompliance with any lawful rules or orders of the commissioner or of a commissioner of another state.

13. The licensee's license has been suspended or revoked in any other state, province, district, or territory for any reason or purpose other than noncompliance with continuing education programs, or noncompliance with mandatory filing requirements imposed upon a licensee by the state, province, district, or territory provided the filing does not directly affect the public interest, safety, or welfare.

14. The applicant or licensee has refused to respond within twenty days to a written request by the commissioner for information regarding any potential violation of this section.

15. Without express prior written approval from the commissioner, the licensee communicates with a person who the licensee knows has contacted the department regarding an alleged violation committed by the licensee in an attempt to have the complainant dismiss the complaint.

SECTION 29. AMENDMENT. Section 26.1-26-46 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-46. License suspension~~,~~ or revocation~~, or refusal~~ - Duty of licensee. Upon suspension~~,~~ or revocation~~, or r~~efusal of a license, the licensee shall forthwith deliver it to the commissioner by personal delivery or by mail.

SECTION 30. AMENDMENT. Section 26.1-39-09.2 of the North Dakota Century Code is amended and reenacted as follows:

26.1-39-09.2. Suspension or revocation of certificate or license for noncompliance or for acceptance of a reduced service fee. The commissioner shall suspend or revoke the certificate of authority of any insurer who intentionally fails to comply with section 26.1-11-07 ~~or 26.1-39-09.1. The commissioner may suspend or revoke the license of any resident agent or broker who agrees to accept or who accepts a service fee in an amount less than the service fee provided for in section 26.1-39-09.1 and may suspend or revoke the license of any nonresident agent who seeks to induce or who induces any resident agent into accepting a service fee in an amount less than the service fee provided for in section 26.1-39-09.1~~.

SECTION 31. REPEAL. Sections 26.1-26-47 and 26.1-39-09.1 of the North Dakota Century Code are repealed.

Approved April 13, 1999
Filed April 14, 1999

CHAPTER 253

HOUSE BILL NO. 1178

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

HEALTH CARE UTILIZATION REVIEW

AN ACT to create and enact sections 26.1-01-07.6 and 26.1-26.4-04.2 of the North Dakota Century Code, relating to medicare provider-sponsored organizations and health care service utilization review; and to amend and reenact section 26.1-26.4-02, subdivision d of subsection 1 of section 26.1-36-04, subsection 22 of section 26.1-36.3-01, subdivision e of subsection 3 of section 26.1-36.3-06, subsection 6 of section 26.1-36.3-06, section 26.1-36.4-03, subsection 8 of section 26.1-47-01, and section 26.1-47-02 of the North Dakota Century Code, relating to health care service utilization review, accident and health insurance, small employer health insurance, and preferred provider organizations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-01-07.6 of the North Dakota Century Code is created and enacted as follows:

26.1-01-07.6. Medicare provider-sponsored organizations. The commissioner of insurance shall adopt rules relating to provider-sponsored organizations as defined in section 4001 of the Balanced Budget Act of 1997 [Pub. L. 105-33; 111 Stat. 312; 42 U.S.C. 1395 et seq.].

[183] **SECTION 2. AMENDMENT.** Section 26.1-26.4-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-02. Definitions. For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the commissioner of insurance.

2. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.

3. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section

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[183] Section 26.1-26.4-02 was also amended by section 3 of Senate Bill No. 2400, chapter 257.

26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

4. "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.

~~4.~~ 5. "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

~~5.~~ 6. "Utilization review agent" means any person or entity performing utilization review, except:

a. An agency of the federal government; or

b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services.

SECTION 3. Section 26.1-26.4-04.2 of the North Dakota Century Code is created and enacted as follows:

26.1-26.4-04.2. Utilization review - Duty of health care insurers. A health care insurer that contracts with another entity to perform utilization review on its behalf remains responsible to ensure that all the requirements of this chapter are met to the same extent the health care insurer would be if it performed the utilization review itself.

SECTION 4. AMENDMENT. Subdivision d of subsection 1 of section 26.1-36-04 of the North Dakota Century Code is amended and reenacted as follows:

d. A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a preexisting disease or physical condition for which ~~first manifested itself in the five years immediately prior to~~ medical advice or treatment was received by the person during the two-year period before the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the end of the two-year period commencing on the effective date of the person's coverage.

SECTION 5. AMENDMENT. Subsection 22 of section 26.1-36.3-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

22. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the

initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty days. An eligible employee or dependent may not be considered a late enrollee, however, if:

a. The individual:

(1) Was covered under qualifying previous coverage at the time of the initial enrollment;

(2) Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce; and

(3) Requests enrollment within ~~sixty-three~~ thirty days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

c. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

d. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.

SECTION 6. AMENDMENT. Subdivision e of subsection 3 of section 26.1-36.3-06 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

(2) Except as permitted under subsection 1 and this subsection, a small employer carrier may not modify a ~~basic or standard~~ health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

SECTION 7. AMENDMENT. Subsection 6 of section 26.1-36.3-06 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

6. ~~This section~~ Subsection 1 does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

SECTION 8. AMENDMENT. Section 26.1-36.4-03 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-03. Limits on preexisting condition exclusions. An insurer may impose a preexisting condition exclusion only if:

1. The exclusion relates to a condition, regardless of the cause of the condition, for which medical diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of the person's coverage.

2. The exclusion extends for a period of not more than twelve months after the effective date of coverage. A group policy may impose an eighteen-month preexisting condition to a late enrollee, as the term late enrollee is defined in section 26.1-36.3-01.

SECTION 9. AMENDMENT. Subsection 8 of section 26.1-47-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

8. "Preferred provider ~~agreement~~ arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter.

[184] **SECTION 10. AMENDMENT.** Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements. Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:

   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

   b. Include mechanisms which are designed to minimize the cost of the health benefit plan. These mechanisms may:

      (1) Provide for the review and control of utilization of health care services.

      (2) Establish a procedure for determining whether health care services rendered are medically necessary.

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[184] Section 26.1-47-02 was also amended by section 9 of Senate Bill No. 2400, chapter 257.

c. Include mechanisms which are designed to preserve the quality of health care.

d. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.

e. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.

f. Provide that either party terminating the contract without cause provide the other party at least sixty days advance written notice of the termination.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

3. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

4. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.

5. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Approved April 7, 1999
Filed April 8, 1999

CHAPTER 254

HOUSE BILL NO. 1175

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

INSURANCE COMPANIES AND AGENTS

AN ACT to create and enact a new section to chapter 26.1-01 and sections 26.1-05-02.1, 26.1-12-11.1, and 26.1-26-11.1 of the North Dakota Century Code, relating to electronic filings, domestic insurance companies, incorporated mutual insurance companies, and authorized lines of business; to amend and reenact sections 26.1-05-02, 26.1-12-01, 26.1-12-06, 26.1-12-11, 26.1-26-01, 26.1-26-11, 26.1-26-25, and 26.1-26-31.1 of the North Dakota Century Code, relating to domestic insurance companies, mutual insurance companies, insurance agents, authorized lines of business, and exceptions from examination requirements; to repeal section 26.1-05-03 of the North Dakota Century Code, relating to organization of a domestic mutual life insurance company; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-01 of the North Dakota Century Code is created and enacted as follows:

Electronic filings allowed.

1. Notwithstanding any other provision of this title, the commissioner may adopt rules that allow either an applicant or a licensee to file documents electronically with the commissioner or the commissioner's designee. The rules may contain procedures for the electronic filing of the following:

   a. Any document required as part of an application for a license under this title;

   b. Any document required to be filed by an applicant or licensee to maintain the license in good standing;

   c. Any fee required under this title; and

   d. Any other document required or permitted to be filed.

2. This section may not be interpreted to supersede any other provision of law that requires the electronic filing of a document or to require an applicant or licensee to make any other filing electronically.

SECTION 2. AMENDMENT. Section 26.1-05-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-05-02. Organization of domestic stock company - Number of persons required - Authorized lines. Any number of persons not less than seven may form a corporation on the stock plan to carry on one or more of the following lines of insurance:

1. ~~Against loss or damage by fire, lightning, cyclone, tornado, hail, or theft.~~ Life and annuity means insurance coverage on human lives including benefits of endowment, annuities, and credit life.

2. ~~Against the risks of inland navigation and transportation.~~ Accident and health means insurance coverage for sickness, disease, injury, accidental death, and disability.

3. ~~Upon the lives of persons, including every kind of insurance pertaining thereto.~~ Property means insurance coverage for direct and consequential loss of or damage to property of every kind.

4. ~~Against accidental injuries including the granting, purchasing, and paying of annuities and indemnities.~~ Casualty means insurance coverage against legal liability including that for death, injury, or disability or damage to real or personal property.

5. ~~To transact fidelity insurance and corporate suretyship.~~ Variable life and annuity means insurance coverage provided under variable life insurance contracts, variable annuities, or any other life insurance or annuity that reflects the investment experience of a separate account.

~~6. Upon automobiles covering in one policy or in separate policies fire, theft, property damage, liability, and collision insurance.~~

~~7. Covering any other hazard not specifically prohibited by the laws of this state as a subject of insurance.~~

~~8. Against legal expense.~~

A stock insurance company incorporated under this chapter may carry the lines of insurance mentioned in this section which have been expressed in its articles of incorporation.

SECTION 3. Section 26.1-05-02.1 of the North Dakota Century Code is created and enacted as follows:

26.1-05-02.1. Authority to define products. The commissioner may adopt rules that define and set forth the specific insurance products found under each line of insurance set forth in section 26.1-05-02.

SECTION 4. AMENDMENT. Section 26.1-12-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-01. Organization of mutual insurance company - Minimum number of members. Any number of persons, not less than twenty, a majority of whom must be bona fide residents of this state, may become, together with others who thereafter may be associated with them or their successors, a body corporate for the purpose of carrying on the business of mutual insurance as provided in this chapter by complying with this chapter. Any number of persons, not less than seven, may form a mutual life insurance company and, with others who may become associated with them or their successors, may become a body corporate for the purpose of carrying on the business of a mutual life insurance company. A mutual life insurance company organized under this chapter may carry insurance upon the lives of persons, including every kind of insurance pertaining thereto.

[185] **SECTION 5. AMENDMENT.** Section 26.1-12-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-06. Bylaws of mutual company - Meetings - Notice - Quorum. The bylaws of any mutual insurance company organized under this chapter ~~or chapter 26.1-05~~ must prescribe the manner of notification to members of all corporation meetings of members and must prescribe what constitutes a quorum of members. A quorum is those members present in person or represented by written proxies. A majority of those voting is sufficient to approve or reject any proposal submitted at any annual or special meeting. Every member of the company is entitled to one vote only. Every member must be notified of the time and place of the holding of the meetings of the company by a written notice or by an imprint on the back of each policy, receipt, or certificate of renewal. In addition, a notice of any annual or special meeting must be published in the official newspaper of the county in which the principal office of the company is located. The notice must be published at least twice, the first publication to be made at least sixty days before the meeting. If a special meeting of members is called, a notice of the time, place, and object of the meeting must be mailed to all members at least sixty days before the meeting.

SECTION 6. AMENDMENT. Section 26.1-12-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-11. Authority to insure or reinsure - ~~Kinds~~ Types of insurance open to mutual company. Any mutual insurance company organized under this chapter may make insurance contracts, and may reinsure or accept reinsurance on any portion thereof, to the extent specified in its articles of incorporation, for the following ~~kinds~~ lines of insurance:

1. ~~Fire, hail, lightning, tornado, and other insurance. Against loss or damage to property, and the loss of use and occupancy thereof, by fire, lightning, hail, tempest, flood, earthquake, frost or snow, explosion with fire ensuing, and explosion with no fire ensuing, except explosion by steam boilers or flywheels; against loss or damage by water caused by the breakage or leakage of sprinklers, pumps or other apparatus, water pipes, plumbing, or their fixtures, erected for extinguishing fires, and against accidental injury to the sprinklers, pumps or other apparatus, water pipes, plumbing, or fixtures; against the risks of inland transportation and navigation; upon automobiles, whether stationary or operated under their own power, against loss or damage by any of the causes or risks specified in this subsection, including also transportation, collision, liability for damage to property resulting from owning, maintaining, or using automobiles, and including burglary and theft, but not including loss or damage by reason of bodily injury to the person.~~ Life and annuity means insurance coverage on human lives including benefits of endowment, annuities, and credit life.

2. ~~Liability insurance. Against loss, expense, or liability by reason of bodily injury or death by accident, disability, sickness, or disease suffered by others for which the insured may be liable or may have assumed~~

[185] Section 26.1-12-06 was also amended by section 1 of House Bill No. 1238, chapter 260.

~~liability.~~ Acc~~ident and health~~ means insurance coverage for sickness, dis~~ease, injury, accidental death, and disability~~.

3. ~~Disability i~~P~~roperty~~ means insurance coverage for direct and con~~sequential loss of or damage to property of every kind~~.

4. ~~Automobile i~~C~~asualty~~ means insurance coverage against legal liability including that for death, injury, or disability or damage to r~~eal or personal property~~.

5. ~~Steam boiler i~~V~~ariable life and annuity~~ means insu~~rance coverage provided under variable life insurance contracts, vari~~able annuities, or any other life insurance or annuity that reflects the inv~~estment experience of a separate account~~.

~~6. Use and occupancy insurance. Against loss from interruption of trade or business which may be the result of any accident or casualty.~~

~~7. Miscellaneous insurance. Against loss or damage by any hazard upon any risk not provided for in this section which is not prohibited by statute or at common law from being the subject of insurance, except life insurance.~~

~~8. Legal expense insurance.~~

SECTION 7. Section 26.1-12-11.1 of the North Dakota Century Code is created and enacted as follows:

26.1-12-11.1. Authority to define products. T~~he product types found under~~ each of the above lines of insurance are those adopted pursuant to section 26.1-05-02.1.

[186] **SECTION 8. AMENDMENT.** Section 26.1-26-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-01. Scope. This chapter governs the qualifications and procedures for the licensing of insurance agents, insurance brokers, insurance consultants, limited insurance representatives, and surplus lines insurance brokers. This chapter applies to all lines of insurance and types of insurers including ~~life, health, property, liability, credit, title, fire, or marine operating on a stock, mutual, reciprocal,~~

[186] Section 26.1-26-01 was also amended by section 4 of Senate Bill No. 2181, chapter 252.

~~benevolent, fraternal, or health service plan, as set forth in this title~~ prepaid legal service organizations and health maintenance organizations.

SECTION 9. AMENDMENT. Section 26.1-26-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-11. License of agent or broker - Lines of insurance. An insurance agent, insurance broker, or surplus lines insurance broker may receive ~~qualification for~~ a license ~~in~~ to market products under one or more of the following lines:

1. Life ~~insurance~~ and annuity ~~contracts~~ means insurance coverage on human lives including benefits of endowment, annuities, and credit life.

2. ~~Sickness, accident,~~ Accident and health ~~insurance~~ means insurance coverage for sickness, disease, injury, accidental death, and disability.

~~3. Credit life insurance and credit accident and health insurance.~~

~~4. Fire and allied lines.~~

~~5. Vehicle liability and vehicle physical damage insurance.~~

~~6. Comprehensive personal and general liability coverage.~~

~~7. Marine and transportation insurance.~~

~~8. Credit and mortgage guarantee insurance.~~

~~9. Burglary and theft insurance.~~

~~10. Crop insurance.~~

~~11. Bail bonds.~~

~~12. Fidelity and surety insurance.~~

~~13. Homeowners' and farmowners' multiple peril insurance.~~

~~14. Commercial multiple peril insurance.~~

~~15.~~ 3. Property ~~and casualty insurance sold in connection with a credit transaction~~ means insurance coverage for direct and consequential loss of or damage to property of every kind.

4. Casualty means insurance coverage against legal liability including that for death, injury, or disability or damage to real or personal property.

~~16. Industrial fire insurance.~~

~~17. Legal expense insurance.~~

~~18.~~ 5. Variable ~~annuities and variable life insurance~~ life and annuity means insurance coverage provided under variable life insurance contracts, variable annuities, or any other life insurance or annuity that reflects the investment experience of a separate account.

~~19. Title insurance.~~

The product types found under each of the above lines of insurance are those adopted pursuant to section 26.1-15-02.1.

SECTION 10. Section 26.1-26-11.1 of the North Dakota Century Code is created and enacted as follows:

26.1-26-11.1. Authority to define procedures and requirements. The commissioner may adopt rules to implement licensing procedures and requirements specific to each line of insurance and each product type within each line of insurance.

[187] **SECTION 11. AMENDMENT.** Section 26.1-26-25 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-25. Exceptions from examination. The requirement for a written examination is subject to the following exceptions:

1. An applicant for a license covering the same line or lines of insurance for which the applicant was licensed under a like resident license in this state, other than a temporary license, within the twelve months next preceding the date of application, unless the previous license was suspended or revoked by the commissioner.

2. A nonresident applicant may be licensed without examination if the commissioner of the state of the applicant's residence certifies, by facsimile signature and seal, that the applicant has passed a similar written examination, or has been a continuous holder prior to the time the written examination was required, of a license like the license being applied for in this state.

3. An applicant who has been licensed under a like license in another state within twelve months prior to the application for a license in this state, and who files with the commissioner the certificate of the public official having supervision of insurance in the other state, by facsimile signature and seal, as to the applicant's license and good standing in such state; provided, however, that the applicant shall take that portion of the examination pertaining to state laws and rules.

4. An applicant who has attained the designation of chartered life underwriter is only required to take that portion of the examination for lines one and ~~eighteen~~ five pertaining to state laws and rules.

5. An applicant who has attained the designation of chartered property and casualty underwriter is only required to take that portion of the examination for lines ~~two through seventeen~~ three and four pertaining to state laws and rules.

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[187] Section 26.1-26-25 was also amended by section 20 of Senate Bill No. 2181, chapter 252.

6. An applicant for a license to act as a limited insurance representative may be licensed without examination ~~in one or more of the following~~ l~~ines:~~

   ~~a. Any t~~i~~cket-selling agent of a common carrier who acts t~~h~~ereunder only with r~~eference to the i~~ssuance ~~of i~~nsurance ~~on personal effects carried as b~~aggage~~, in connection with the t~~ransportation ~~provided by the common carrier, or an applicant selling limited travel accident i~~nsurance ~~in t~~ransportation t~~erminals.~~

   ~~b. Any other l~~ines ~~that~~ to market a specific product type if the commissioner finds by rule ~~do~~ the specific product type does not require the same professional competency demanded for ~~a l~~icense ~~as an agent or broker~~ other product types.

7. An applicant for a license to write only a specific product type may be licensed subject to reduced examination requirements if the commissioner finds by rule that the requirements for licensure would otherwise be too burdensome and unrelated to that specific product type.

SECTION 12. AMENDMENT. Section 26.1-26-31.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-31.1. Continuing education required - Exceptions.

1. Except as otherwise provided in this section, any person licensed as an insurance agent, insurance broker, surplus lines insurance broker, or insurance consultant shall provide the commissioner evidence, as required by the commissioner, that the person attended or participated in continuing education of not less than fifteen hours per year of approved coursework, of which seven and one-half hours per year must be classroom hours. The commissioner may waive the requirement of seven and one-half hours per year of classroom hours. The commissioner may reduce the minimum number of hours per year of approved coursework for any person having a license limited to a ~~single line of i~~nsurance ~~as d~~escribed ~~in section 26.1-26-11~~ specific product type. The continuing education advisory task force may recommend granting up to fifteen hours continuing education credit for nationally recognized insurance education correspondence programs. The commissioner shall review the task force's recommendation, and the commissioner may approve up to fifteen hours of credit. Credit for courses attended in any one year over the minimum number of hours of coursework required may be credited to the year next preceding the year in which they were earned or to the year next following the year in which they were earned. Reports of continuing education must be made at the end of each two-year period following licensure. No continuing education is required of an agent licensed for the sale of life insurance or sickness, accident, and health insurance, or both, who is at least sixty-two years of age, who has a combined total years of continuous licensure as such agent and years of age which equals eighty-five, and whose commissions from new business each year do not exceed ten thousand dollars. No continuing education is required of an insurance agent who sells only group credit life or group credit accident and health insurance to cover an indebtedness.

2. The commissioner shall by rule divide the persons subject to this section into two equal segments for the purpose of reporting, as follows:

   a. One-half of the persons shall file their report showing at least the minimum number of required hours of approved coursework for the previous two years within thirty days of January first of every odd-numbered year.

   b. One-half of the persons shall file a report showing at least the minimum number of required hours of approved coursework for the previous two years within thirty days of January first of every even-numbered year.

3. All persons licensed after January 1, 1989, shall report within thirty days of the first day of January of the year following the second anniversary of the person's licensure.

SECTION 13. REPEAL. Section 26.1-05-03 of the North Dakota Century Code is repealed.

SECTION 14. EFFECTIVE DATE. This Act becomes effective on July 1, 2000.

Approved April 9, 1999
Filed April 9, 1999

CHAPTER 255

SENATE BILL NO. 2156

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

ACCOUNTING PRACTICES AND PROCEDURES MANUAL ADOPTION

AN ACT to create and enact a new section to chapter 26.1-02 of the North Dakota Century Code, relating to adoption of the national association of insurance commissioners accounting practices and procedures manual.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-02 of the North Dakota Century Code is created and enacted as follows:

Accounting practices and procedures manual. The commissioner shall adopt by rule the accounting practices and procedures manual published by the national association of insurance commissioners. The provisions of the accounting practices and procedures manual adopted by the commissioner govern the statutory accounting practices of all insurance companies, including health maintenance organizations, licensed to do business in this state. Any reference to the accounting practices and procedures manual in this title means the manual the commissioner adopts by rule, unless specifically stated otherwise.

Approved March 4, 1999
Filed March 4, 1999

CHAPTER 256

HOUSE BILL NO. 1176

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

HEALTH ORGANIZATION RISK-BASED CAPITAL

AN ACT to create and enact chapter 26.1-03.2 of the North Dakota Century Code, relating to risk-based capital for health organizations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-03.2 of the North Dakota Century Code is created and enacted as follows:

26.1-03.2-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Adjusted risk-based capital report" means a risk-based capital report which has been adjusted by the commissioner in accordance with section 26.1-03.2-02.

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

3. "Domestic health organization" means a health organization domiciled in this state.

4. "Foreign health organization" means a health organization that is licensed to do business in this state but is not domiciled in this state.

5. "Health organization" means a health maintenance organization, prepaid limited health service organization, nonprofit health service corporation, or other managed care organization licensed by the commissioner to do business in this state. "Health organization" does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer that is otherwise subject to either the life or property and casualty risk-based capital requirements.

6. "Risk-based capital instructions" means the risk-based capital report including risk-based capital instructions adopted by the national association of insurance commissioners, as these 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.

7. "Risk-based capital level" means a health organization'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 health organization, the product of 2.0 and its authorized control level risk-based capital.

c. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

d. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

8. "Risk-based capital plan" means a comprehensive financial plan containing the elements specified in subsection 2 of section 26.1-03.2-03. If the commissioner rejects the risk-based capital plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan must be called the "revised risk-based capital plan".

9. "Risk-based capital report" means the report required in section 26.1-03.2-02.

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

a. A health organization's statutory capital and surplus, net worth, as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under section 26.1-03-07 or, in the case of a health maintenance organization, section 26.1-18.1-08; and

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

26.1-03.2-02. Risk-based capital reports.

1. On or before each March first, a domestic health organization 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 such information as is required by the risk-based capital instructions. In addition, a domestic health organization 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 health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its risk-based capital report not later than the latter 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 health organization's risk-based capital must be determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take the following into account, and may adjust for the covariance between, as determined in each case by applying the factors in the manner set forth in the risk-based capital instructions:

   a. Asset risk;

   b. Credit risk;

   c. Underwriting risk; and

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

3. Net worth 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 health insurance. Accordingly, health organizations should seek to maintain capital above the risk-based capital levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure a health organization 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.

4. If a domestic health organization 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 shall notify the health organization of the adjustment. The notice must contain a statement of the reason for the adjustment. A risk-based capital report as so adjusted is referred to as an "adjusted risk-based capital report".

26.1-03.2-03. 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 a health organization which indicates that the health organization'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;

   b. Notification by the commissioner to the health organization of an adjusted risk-based capital report that indicates an event in subdivision a, provided the health organization does not challenge the adjusted risk-based capital report under section 26.1-03.2-07; or

   c. If, pursuant to section 26.1-03.2-07, a health organization challenges an adjusted risk-based capital report that indicates the event in subdivision a, the notification by the commissioner to the health organization that the commissioner, after a hearing, has rejected the health organization's challenge.

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

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

   b. Contains proposals of corrective actions which the health organization intends to take and which would be expected to result in the elimination of the company action level event;

   c. Provides projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and risk-based capital levels. 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. Identifies the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

   e. Identifies the quality of, and problems associated with, the health organization'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 health organization challenges an adjusted risk-based capital report pursuant to section 26.1-03.2-07, within forty-five days after notification to the health organization that the commissioner, after a hearing, has rejected the health organization's challenge.

4. Within sixty days after the submission by a health organization of a risk-based capital plan to the commissioner, the commissioner shall notify the health organization whether the risk-based capital plan shall 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 health organization 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 health organization 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 health organization challenges the notification from the commissioner under section 26.1-03.2-07, within forty-five days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

5. In the event of a notification by the commissioner to a health organization that the health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the commissioner, subject to the health organization's right to a hearing under section 26.1-03.2-07, may specify in the notification that the notification constitutes a regulatory action level event.

6. Every domestic health organization 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 health organization is authorized to do business if:

a. The state has a risk-based capital provision substantially similar to subsection 1 of section 26.1-03.2-08; and

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

26.1-03.2-04. Regulatory action level event.

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

a. The filing of a risk-based capital report by the health organization which indicates that the health organization'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. Notification by the commissioner to a health organization of an adjusted risk-based capital report that indicates the event in subdivision a, provided the health organization does not challenge the adjusted risk-based capital report under section 26.1-03.2-07;

c. If, pursuant to section 26.1-03.2-07, the health organization challenges an adjusted risk-based capital report that indicates the event in subdivision a, the notification by the commissioner to the health organization that the commissioner, after a hearing, has rejected the health organization's challenge;

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

e. The failure of the health organization to submit a risk-based capital plan to the commissioner within the time period set forth in subsection 3 of section 26.1-03.2-03;

f. Notification by the commissioner to the health organization that:

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

(2) Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under section 26.1-03.2-07;

g. If, pursuant to section 26.1-03.2-07, the health organization challenges a determination by the commissioner under subdivision f, the notification by the commissioner to the health organization that the commissioner, after a hearing, has rejected the challenge;

h. Notification by the commissioner to the health organization that the health organization 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 health organization 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 health organization has not challenged the determination under section 26.1-03.2-07; or

i. If, pursuant to section 26.1-03.2-07, the health organization challenges a determination by the commissioner under subdivision h, the notification by the commissioner to the health organization that the commissioner, after a hearing, has rejected the challenge.

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

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

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

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

3. In determining corrective actions, the commissioner may take into account factors the commissioner deems relevant with respect to the health organization risk based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the health organization, 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 health organization challenges an adjusted risk-based capital report pursuant to section 26.1-03.2-07 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

   c. If the health organization challenges a revised risk-based capital plan pursuant to section 26.1-03.2-07 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the health organization that the commissioner has, after a hearing, reject the health organization's challenge.

4. The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health organization's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations, including contractual relationships, of the health organization and formulate the corrective order with respect to the health organization. The fees, costs, and expenses relating to consultants must be borne by the affected health organization or such other party as directed by the commissioner.

26.1-03.2-05. 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 health organization which indicates that the health organization's total adjust 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 health organization of an adjusted risk-based capital report that indicates the event in subdivision a, provided the health organization does not challenge the adjusted risk-based capital report under section 26.1-03.2-07;

   c If, pursuant to section 26.1-03.2-07, the health organization challenges an adjusted risk-based capital report that indicates the event in subdivision a, notification by the commissioner to the health organization that the commissioner, after a hearing, has rejected the health organization's challenge;

d. The failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the health organization has not challenged the corrective order under section 26.1-03.2-07; or

e. If the health organization has challenged a corrective order under section 26.1-03.2-07 and the commissioner, after a hearing, has rejected the challenge or modified the corrective order, the failure of the health organization 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 a health organization, the commissioner shall:

a. Take such actions as are required under section 26.1-03.2-04 regarding a health organization with respect to which a regulatory action level event has occurred; or

b. If the commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under chapter 26.1-06.1. 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 shall have the rights, powers, and duties with respect to the health organization as are set forth in chapter 26.1-06.1. If the commissioner takes actions under this subdivision pursuant to an adjusted risk-based capital report, the health organization is entitled to such protections as are afforded to health organizations under the provisions of chapter 26.1-06.1 pertaining to summary proceedings.

26.1-03.2-06. 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 health organization's total adjusted capital is less than its mandatory control level risk-based capital;

b. Notification by the commissioner to the health organization of an adjusted risk-based capital report that indicates the event in subdivision a, provided the health organization does not challenge the adjusted risk-based capital report under section 26.1-03.2-07; or

c. If, pursuant to section 26.1-03.2-07, the health organization challenges an adjusted risk-based capital report that indicates the event in subdivision a, notification by the commissioner to the health organization that the commissioner, after a hearing, has rejected the health organization's challenge.

2. In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization 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 shall have the rights, powers, and duties with respect to the health organization as are set forth in chapter 26.1-06.1. If the commissioner takes actions pursuant to an adjusted risk-based capital report, the health organization is entitled to the protections 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.

26.1-03.2-07. Hearings. Upon the occurrence of any of the following events, the health organization shall have the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the commissioner. The health organization 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 health organization's request for a hearing, the commissioner shall set a date for the hearing, which may not be less than ten nor more than thirty days after the date of the health organization's request. The events include:

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

2. Notification to a health organization by the commissioner that:

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

   b. Notification constitutes a regulatory action level event with respect to the health organization;

3. Notification to a health organization by the commissioner that the health organization 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 health organization to eliminate the company action level event with respect to the health organization in accordance with its risk-based capital plan or revised risk-based capital plan; or

4. Notification to a health organization by the commissioner of a corrective order with respect to the health organization.

26.1-03.2-08. Confidentiality - Prohibition on announcements - Prohibition on use in ratemaking.

1. All risk-based capital reports, to the extent the information 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 a health organization performed pursuant to this chapter, and any corrective order issued by the commissioner pursuant to examination or analysis, with respect to a domestic health organization or foreign health organization, which are filed with the commissioner constitute information that might be damaging to the health organization if made available to its competitors, and therefore shall 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 pursuant to this chapter or any other provision of the insurance laws of this state.

2. It is the judgment of the legislature that the comparison of a health organization's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for corrective action with respect to the health organization and is not intended as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of 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 a 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 health organization, or of any component derived in the calculation, by any health organization, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its risk-based capital levels, or any of them, or an inappropriate comparison of any other amount to the health organization's risk-based capital levels is published in any written publication and the health organization 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 health organization 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 legislature 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 health organizations and the need for possible corrective action with respect to health organizations 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 a health organization or any affiliate is authorized to write.

26.1-03.2-09. Supplemental provisions - Rules - Exemption.

1. The provisions of this chapter are supplemental to any other provisions of the laws of this state, and do not preclude or limit any other powers or duties of the commissioner under such laws, including chapter 26.1-06.1.

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

3. The commissioner may exempt from the application of this chapter a domestic health organization that:

a. Writes direct business only in this state;

b. Assumes no reinsurance in excess of five percent of direct premium written; and

c. Writes direct annual premiums for comprehensive medical business of less than an amount determined by the commissioner; or

d. Is a limited health service organization that covers less than a number of lives determined by the commissioner.

26.1-03.2-10. Foreign health organizations.

1. a. A foreign health organization, upon the written request of the commissioner, shall submit to the commissioner a risk-based capital report for the calendar year just ended, the latter of:

(1) The date a risk-based capital report would be required to be filed by a domestic health organization under this chapter; or

(2) Fifteen days after the request is received by the foreign health organization.

b. A foreign health organization, at the written request of the commissioner, shall promptly submit to the commissioner a copy of any risk-based capital plan that is filed with the insurance commissioner of any other state.

2. In the event of a company action level event, regulatory action level event, or authorized control level event with respect to a foreign health organization as determined under the risk-based capital statute applicable in the state of domicile of the health organization or, if no risk-based capital statute is in force in that state, under the provisions of this chapter, if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization 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 statute is in force in that state, under section 26.1-03.2-03, the commissioner may require the foreign health organization to file a risk-based capital plan with the commissioner. In such event, the failure of the foreign health organization to file a risk-based capital plan with the commissioner is grounds to order the health organization 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 a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, 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 health organizations found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

26.1-03.2-11. Immunity. There is no liability on the part of, and no cause of action shall 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.

26.1-03.2-12. Notices. All notices by the commissioner to a health organization which may result in regulatory action under this chapter is effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission is effective upon the health organization's receipt of notice.

26.1-03.2-13. Phasein provision. For risk-based capital reports required to be filed by health organizations with respect to 1999, the following requirements apply in lieu of the provisions of sections 26.1-03.2-03, 26.1-03.2-04, 26.1-03.2-05, and 26.1-03.2-06:

1. In the event of a company action level event with respect to a domestic health organization, the commissioner shall take no regulatory action under this chapter.

2. In the event of a regulatory action level event under subdivision a, b, or c of subsection 1 of section 26.1-03.2-04, the commissioner shall take the actions required under section 26.1-03.2-03.

3. In the event of a regulatory action level event under subdivision d, e, f, g, h, or i of subsection 1 of section 26.1-03.2-04 or an authorized control level event, the commissioner shall take the actions required under section 26.1-03.2-04 with respect to the health organization.

4. In the event of a mandatory control level event with respect to a health organization, the commissioner shall take the actions required under section 26.1-03.2-05 with respect to the health organization.

Approved April 7, 1999
Filed April 8, 1999

CHAPTER 257

SENATE BILL NO. 2400

(Senators Kilzer, DeMers)
(Representatives Berg, Rose)

HEALTH INSURANCE PRACTICES

AN ACT to create and enact three new subsections to section 26.1-04-03, two new subsections to section 26.1-26.4-02, and four new sections to chapter 26.1-36 of the North Dakota Century Code, relating to fairness in health insurance practices, disclosure of health plan information, confidentiality of medical information maintained by health carriers, contract limitations, and health care grievance procedures; and to amend and reenact subsection 14 of section 26.1-04-03, subsection 9 of section 26.1-26.4-04, and section 26.1-47-02 of the North Dakota Century Code, relating to prohibited health insurance practices, health care utilization review procedures, and preferred provider arrangements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[188] **SECTION 1. AMENDMENT.** Subsection 14 of section 26.1-04-03 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

14. As used in subsections 15 ~~and~~, 16, and section 2 of this Act, unless the context otherwise requires:

    a. "Entity" includes a third-party administrator ~~or other person with responsibility for contracts with health care providers under a health plan~~, an insurance company as defined in section 26.1-02-01, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation.

    b. "Health care provider" means a person that delivers, administers, or supervises health care products or services, for profit or otherwise, in the ordinary course of business or professional practice.

    c. "Health plan" means any public or private plan or arrangement that provides or pays the cost of health benefits, including any organization of health care providers that furnishes health services under a contract or agreement with this type of plan.

    d. "Medical communication" means any communication, other than a knowing and willful misrepresentation, made by a health care provider to a patient regarding the health care needs or treatment options of the patient and the applicability of the health plan to the

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[188] Section 26.1-04-03 was also amended by section 4 of Senate Bill No. 2180, chapter 251, and section 2 of Senate Bill No. 2400, chapter 257.

patient's needs or treatment. The term includes communications concerning:

(1) Tests, consultations, and treatment options;

(2) Risks or benefits associated with tests, consultations, and options;

(3) Variation in experience, quality, or outcome among any health care providers or health care facilities providing any medical service;

(4) The process, basis, or standard used by an entity to determine whether to authorize or deny health care services or benefits; and

(5) Financial incentives or disincentives based on service utilization provided by an entity to a health care provider.

e. "Patient" includes a former, current, or prospective patient or the guardian or legal representative of any former, current, or prospective patient.

[189] **SECTION 2.** Three new subsections to section 26.1-04-03 of the 1997 Supplement to the North Dakota Century Code are created and enacted as follows:

Incentives to withhold medically necessary care. An entity may not offer a health care provider, and a contract with a health care provider under a health plan may not contain, an incentive plan that includes a specific payment made to, or withheld from, the provider as an inducement to deny, reduce, limit, or delay medically necessary care covered by the health plan and provided with respect to a patient. This subsection does not prohibit incentive plans, including capitation payments or shared-risk arrangements, that are not tied to specific medical decisions with respect to a patient. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void. As used in this subsection, "medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury, disease, or its symptoms which are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This definition does not preclude an entity from establishing a definition of "medically necessary care" for determining which services are covered by the health plan.

Retaliation for patient advocacy. An entity may not take any of the following actions against a health care provider solely because the

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[189] Section 26.1-04-03 was also amended by section 4 of Senate Bill No. 2180, chapter 251, and section 1 of Senate Bill No. 2400, chapter 257.

provider, in good faith, reports to state or federal authorities an act or practice by the entity that jeopardizes patient health or welfare, or advocates on behalf of a patient in a utilization review program or grievance procedure:

a. Refusal to contract with the health care provider;

b. Termination of or refusal to renew a contract with the health care provider;

c. Refusal to refer patients to or allow others to refer patients to the health care provider; or

d. Refusal to compensate the health care provider for covered services that are medically necessary.

Unfair reimbursement. An entity may not require that a health care provider receive under a health plan, pursuant to policies of the entity or a contract with the health care provider, the lowest payment for services and items that the health care provider charges or receives from any other entity. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void.

[190] **SECTION 3.** Two new subsections to section 26.1-26.4-02 of the North Dakota Century Code are created and enacted as follows:

"Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

"Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

[191] **SECTION 4. AMENDMENT.** Subsection 9 of section 26.1-26.4-04 of the North Dakota Century Code is amended and reenacted as follows:

9. ~~Utilization review agents shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for an enrollee or the enrollee's representative to notify the utilization review agent and request certification or continuing treatment for that condition.~~ When

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[190] Section 26.1-26.4-02 was also amended by section 2 of House Bill No. 1178, chapter 253.

[191] Section 26.1-26.4-04 was also amended by section 2 of House Bill No. 1136, chapter 264.

conducting utilization review or making a benefit determination for emergency services:

a. A utilization review agent may not deny coverage for emergency services and may not require prior authorization of these services.

b. Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

SECTION 5. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Information disclosure. An insurance company, as defined in section 26.1-02-01, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless that insurer makes available to persons covered under the policy or contract a plan description that discloses in writing the terms and conditions of the policy or contract. The plan description must use the plain and ordinary meaning of words so as to reasonably ensure comprehension by a layperson and must be made available to each person covered under the contract, in any manner reasonably assuring availability prior to the delivery, issuance, execution, or renewal of the policy or contract.

1. The information required to be disclosed by the insurer must include, in addition to any other disclosures required by law:

a. A general description of benefits and covered services, including benefit limits and coverage exclusions and the definition of medical necessity used by the insurer in determining whether benefits will be covered;

b. A general description of the insured's financial responsibility for payment of premiums, deductibles, coinsurance, and copayment amounts, including any maximum limitations on out-of-pocket expenses, any maximum limits on payments for health care services, and the maximum out-of-pocket costs for services that are provided by nonparticipating health care professionals;

c. A general explanation of the extent to which benefits and services may be obtained from nonparticipating providers, including any out-of-network coverage or options;

d. A general explanation of the extent to which a person covered under the policy or contract may select from among participating providers and any limitations imposed on the selection of participating health care providers;

e. A general description of the insurer's use of any prescription drug formulary or any other general limits on the availability of prescription drugs;

f. A general description of the procedures and any conditions for persons covered under the policy or contract to change participating primary and specialty providers;

g. A general description of the procedures and any conditions for obtaining referrals;

h. A general description of the procedure for providing emergency services, including an explanation of what constitutes an emergency situation and notice that emergency services are not subject to prior authorization, the procedure for obtaining emergency services and any cost-sharing applicable to emergency services, including out-of-network services, and any limitation on access to emergency services;

i. A general description of any utilization review policies and procedures, including a description of any required prior authorizations or other requirements for health care services and appeal procedures;

j. A general description of all complaint or grievance rights and procedures used to resolve disputes between the insurer and persons covered under the policy or contract or a health care provider, including the method for filing grievances and the timeframes and circumstances for acting on grievances and appeals;

k. A general description of any methods used by the insurer for providing financial payment incentives or other payment arrangements to reimburse health care providers;

l. Notice of appropriate mailing addresses and telephone numbers to be used by persons covered under the policy or contract in seeking information or authorization for treatment;

m. If applicable, notice of the provisions required by section 26.1-47-03 that ensure access to health care services in preferred provider arrangements; and

n. Notice that the information described in subsection 2 is available upon request.

2. An insurer shall provide the following written information if requested by a person covered under a policy or contract:

a. A description of any process for credentialing participating health care providers;

b. A description of the policies and procedures established to ensure confidentiality of patient information;

c. A description of the procedures followed by the insurer to make decisions about the experimental nature of individual drugs, medical devices, or treatments;

d. With regard to any preferred provider arrangement or other network health plan, a list by specialty of the name and location of participating health care providers and the number, types, and geographic distribution of providers participating in the health plan; and

e. Whether a specifically identified drug is included or excluded from coverage.

3. Nothing in this section may be construed as preventing an insurer from making the information under subsections 1 and 2 available to a person covered under the policy or contract through a handbook or similar publication.

SECTION 6. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Confidentiality of medical information.

1. An insurance company, as defined in section 26.1-02-01, health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless confidentiality of medical information is assured pursuant to this section. An insurer shall adopt and maintain procedures to ensure that all identifiable information maintained by the insurer regarding the health, diagnosis, and treatment of persons covered under a policy or contract is adequately protected and remains confidential in compliance with all federal and state laws and regulations and professional ethical standards. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a person covered under a policy or contract, or a prospective insured, obtained by an insurer from that person or from a health care provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except:

   a. If the data or information identifies the covered person or prospective insured upon a written, dated, and signed approval by the covered person or prospective insured, or by a person authorized to provide consent pursuant to section 23-12-13 for a minor or an incapacitated person;

   b. If the data or information identifies the health care provider upon a written, dated, and signed approval by the provider. However, this subdivision may not be construed to prohibit an insurer from disclosing data or information pursuant to chapter 23-01.1 or from disclosing, as part of a contract or agreement in which the health care provider is a party, data or information that identifies a provider as part of mutually agreed upon terms and conditions of the contract or agreement;

   c. If the data or information does not identify either the covered person or prospective insured or the health care provider, the data or information may be disclosed upon request for use for statistical purposes or research;

   d. Pursuant to statute or court order for the production or discovery of evidence; or

e. In the event of a claim or litigation between the covered person or prospective insured and the insurer in which the data or information is pertinent.

2. An insurer may claim any statutory privileges against disclosure that the health care provider who furnished the information to the insurer is entitled to claim.

3. This section may not be construed to prevent disclosure necessary for an insurer to conduct utilization review or management consistent with the standards imposed by chapter 26.1-26.4, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with health care providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law. Nor may this section be construed to limit the insurance commissioner's access to records of the insurer for purposes of enforcement or other activities related to compliance with state or federal laws; however, medical records acquired by the commissioner as part of an examination of an insurer's business practices under section 26.1-03-19.2 or any other regulatory action or proceeding commenced by the commissioner are confidential.

SECTION 7. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Contract limitations.

1. An insurance company as defined by section 26.1-02-01 issuing a health and accident policy, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not terminate a practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose sanctions on any practitioner solely for an excessive or inappropriate practice pattern unless the requirements of this section are met. If a practitioner engages in an excessive or inappropriate practice pattern for the practitioner's specialty, the entity shall inform the practitioner, in writing, as to the manner in which the practitioner's practice is excessive or inappropriate. The entity shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the practitioner's practice pattern. If the excessive or inappropriate practice pattern continues, the entity may impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable. If considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner as nonpayable in the absence of the committee's recommendation to do so. All reports, practice profiles, data, and proceedings of the entity relative to a practitioner who is sanctioned, terminated, or considered for designation as nonpayable are confidential and may not be disclosed or be subject to subpoena or other legal process. Nonpayable status under

this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section "practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice in this state.

2. If the entity uses a practice profile as a factor to evaluate a practitioner's practice pattern, the entity shall provide upon request of the practitioner at any time, a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the practitioner and the manner in which the practice profile is used to evaluate the practitioner. An entity may not sanction a practitioner, terminate a practitioner's participating contract, or designate a practitioner as nonpayable on the basis of a practice profile without informing the practitioner of the specific data underlying those findings. For purposes of this section, a "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning the cost, quality, or quantity of services rendered by an individual practitioner, group of practitioners, or preferred provider. In addition, an entity in developing practice profiles or otherwise measuring practitioner performance shall:

   a. Make severity adjustments, including allowances for the severity of illness or condition of the patient mix and allowances for patients with multiple illnesses or conditions;

   b. Periodically evaluate, with input from specialty-specific practitioners as appropriate, the quality and accuracy of practice profiles, data sources, and methodologies;

   c. Develop and implement safeguards to protect against the unauthorized use or disclosure of practice profiles; and

   d. Provide the opportunity for any practitioner at any time to examine the accuracy, completeness, or validity of any practice profile concerning the practitioner and to prepare a written response to the profile. The entity shall negotiate in good faith with the practitioner to correct any inaccuracies or to make the profile complete. If the inaccuracies or deficiencies are not corrected to the satisfaction of the practitioner, the entity shall submit the written response prepared by the practitioner along with the profile at the time the profile is used pursuant to subsection 1 or provided to any third party consistent with section 6 of this Act.

SECTION 8. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Grievance procedures.

1. An accident and health insurance policy may not be delivered or issued for delivery by an insurance company, as defined in section 26.1-02-01, or any other entity providing a plan of health insurance subject to state insurance regulation to a person in this state unless the entity establishes and maintains a grievance procedure for resolving complaints by covered persons and providers and addressing questions and concerns regarding any aspect of the plan, including access to and availability of

services, quality of care, choice and accessibility of providers, and network adequacy. The procedure must include a system to record and document all grievances since the date of its last examination of the grievances.

2. The procedure must be approved by the insurance commissioner. The commissioner may examine the grievance procedures.

[192] **SECTION 9. AMENDMENT.** Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements. Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:

   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

   b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to ~~minimize the cost of the health benefit plan. These mechanisms may:~~

      ~~(1)~~ ~~Provide for the~~ review and control ~~of~~ the utilization of health care services~~.~~

      ~~(2)~~ ~~Establish~~ and establish a procedure for determining whether health care services rendered are medically necessary.

   c. Include mechanisms which are designed to preserve the quality of health care.

   d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

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[192] Section 26.1-47-02 was also amended by section 10 of House Bill No. 1178, chapter 253.

3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.

Approved April 1, 1999
Filed April 2, 1999

CHAPTER 258

HOUSE BILL NO. 1209

(Representatives Dorso, Kempenich, Severson)

LOW-RISK INCENTIVE FUND INVESTMENT AND TAX CREDITS

AN ACT to create and enact a new subsection to section 26.1-05-19 of the North Dakota Century Code, relating to an insurance company's authorized investment of funds in a North Dakota low-risk incentive fund; to amend and reenact sections 26.1-50-06 and 26.1-50-07 of the North Dakota Century Code, relating to tax credits available to a North Dakota low-risk incentive fund and the admitted assets of insurers; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-05-19 of the 1997 Supplement to the North Dakota Century Code is created and enacted as follows:

Loans, securities, or investments in a North Dakota low-risk incentive fund organized under chapter 26.1-50. The aggregate admitted value of the company's investment under this subsection may not at anytime exceed the lesser of five percent of the company's admitted assets or the amount equal to the company's capital and surplus in excess of the minimum capital and surplus required by law. A company making an investment under this subsection may value at par any investment purchased at par.

SECTION 2. AMENDMENT. Section 26.1-50-06 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-50-06. Tax credit - Penalty. If the requirements of this chapter are met, an insurer is entitled to a credit against taxes due under section 26.1-03-17 or 26.1-11-06 as determined under this section. If the insurer is a member of an insurance holding company system, the insurer or any affiliate insurer is entitled to a credit against taxes under section 26.1-03-17 or 26.1-11-06 as determined under this section.

1. An insurer making or participating in a loan under this chapter or an affiliate insurer under this chapter is entitled to a premium tax credit calculated for each calendar year the loan is in place. The amount of the credit is the difference between:

   a. The participating insurer's share of the interest earned on the loan during the calendar year; and

   b. The participating insurer's share of an amount of interest that would have been earned during the same period by applying an interest rate, calculated by adding three hundred basis points to a comparable treasury security rate at the date of the issuance of the loan.

2. The maximum credit allowed an insurer for any calendar year is the amount of interest that would have been earned during the period by applying an interest rate of three hundred basis points. A credit may not be allowed if the interest earned exceeds the interest that would have been earned by applying the calculation in subdivision b of subsection 1.

3. The credit may not exceed the total amount of the insurer's tax liability under subsection 1 of section 26.1-03-17 and no unused credit may be carried forward.

4. Credits under this section for all insurers may not exceed seven hundred fifty thousand dollars in a calendar year.

SECTION 3. AMENDMENT. Section 26.1-50-07 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-50-07. Assets of insurers. The amount of a loan made by an insurer or the amount of an insurer's participation in a loan made under this chapter may not be considered or reported on the insurer's annual statement as an admitted asset except to the extent provided under ~~subsection 33 of~~ section 26.1-05-19.

Approved March 23, 1999
Filed March 23, 1999

CHAPTER 259

SENATE BILL NO. 2263

(Senators Klein, Tallackson)
(Representatives Mahoney, Monson)

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION

AN ACT to create and enact chapter 26.1-42.1 of the North Dakota Century Code, relating to an insurance guaranty association for property and casualty insurance; to amend and reenact subsection 9 of section 26.1-06.1-03, section 26.1-14-15, subdivision b of subsection 3 of section 26.1-40-15.1, subsection 3 of section 26.1-40-15.5, subsection 1 of section 26.1-41-18, and subsection 3 of section 26.1-46-04 of the North Dakota Century Code; and to repeal chapter 26.1-42 of the North Dakota Century Code, relating to the insurance guaranty association.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 9 of section 26.1-06.1-03 of the North Dakota Century Code is amended and reenacted as follows:

9. "Guaranty association" means the North Dakota insurance guaranty association created by chapter ~~26.1-42~~ 26.1-42.1 or the North Dakota life and health insurance guaranty association created by chapter 26.1-38.1, and any other similar entity now or hereafter created by the legislative assembly for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entity now in existence in or hereafter created by the legislature of any other state.

SECTION 2. AMENDMENT. Section 26.1-14-15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-14-15. Optional membership in insurance guaranty association. The company may not be a member insurer under chapter ~~26.1-42~~ 26.1-42.1 unless the board of directors by appropriate resolution, certified to and filed with the commissioner on or before December thirty-first following the issuance of its certificate of authority, elects to become a member. If there is an affirmative election, the company becomes a member of the insurance guaranty association effective July first of the following year. The election is irrevocable. In absence of a timely election, no policyholder, claimant, or creditor of the company may receive any payment by the insurance guaranty association.

SECTION 3. AMENDMENT. Subdivision b of subsection 3 of section 26.1-40-15.1 of the North Dakota Century Code is amended and reenacted as follows:

b. There is an applicable policy or bond, but the insurer or issuer thereof refuses to provide coverage, denies coverage, or is or becomes insolvent as defined in ~~subsection 4 of~~ section ~~26.1-42-02~~ 26.1-42.1-02.

SECTION 4. AMENDMENT. Subsection 3 of section 26.1-40-15.5 of the North Dakota Century Code is amended and reenacted as follows:

3. ~~Whenever~~ If an insurer makes payment under uninsured or underinsured motorist coverages because of an insurer insolvency, as defined in ~~subsection 4 of~~ section ~~26.1-42-03~~ 26.1-42.1-02, the paying insurer's rights of reimbursement and subrogation do not include any rights of recovery against the insured of the insolvent insurer~~, nor~~ or against the North Dakota guaranty fund, except for the amount ~~which~~ that is in excess of the limits of liability of the policy of the insolvent insurer.

SECTION 5. AMENDMENT. Subsection 1 of section 26.1-41-18 of the North Dakota Century Code is amended and reenacted as follows:

1. Basic no-fault insurers authorized to provide basic no-fault benefits in this state shall organize, participate in, and maintain an assigned claims plan to provide that an injured person who suffers economic loss and is eligible for basic no-fault benefits under section 26.1-41-06, other than a person not entitled to benefits under section 26.1-41-07, may obtain basic no-fault benefits through the plan if:

   a. Basic no-fault benefits are not applicable to the injury for some reason other than those specified in section 26.1-41-07; or

   b. Basic no-fault benefits applicable to the injury are inadequate to provide the contracted-for benefits because of financial inability of a basic no-fault insurer to fulfill its obligations.

   Payments made by the assigned claims plan pursuant to this subsection constitute covered claims under chapter ~~26.1-42~~ 26.1-42.1.

SECTION 6. Chapter 26.1-42.1 of the North Dakota Century Code is created and enacted as follows:

26.1-42.1-01. Scope. This chapter applies to every kind of direct insurance, except:

1. Life, annuity, health, or disability insurance;

2. Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

3. Fidelity or surety bonds or any other bonding obligations;

4. Credit insurance, vendors' single interest insurance, collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

5. Insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property; for indemnification for repair, replacement, or service; for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear; or for reimbursement for the liability incurred by the issuer of agreements or service contracts that provide these benefits;

6. Title insurance;

7. Ocean marine insurance;

8. Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of that insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

9. Any insurance provided by or guaranteed by government.

26.1-42.1-02. Definitions. As used in this chapter:

1. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December thirty-first of the year immediately following the date the insurer becomes an insolvent insurer.

2. "Association" means the North Dakota insurance guaranty association created under section 26.1-42.1-03.

3. "Claimant" means any insured making a first party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

4. "Control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing at least ten percent of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

5. "Covered claim" means an unpaid claim, including an unpaid claim for unearned premiums, submitted by a claimant, that arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this chapter applies, issued by an insurer, if this insurer becomes an insolvent insurer after the effective date of this chapter and the claimant or insured is a resident of this state at the time of the insured event; provided that for entities other than an individual, the residence of a claimant, insured, or policyholder is the state in which the entity's principal place of business is located at the time of the insured event; or the claim is a first-party claim for damage to property with a permanent location is this state. The term does not include:

   a. Any amount awarded as punitive or exemplary damages;

   b. Any amount sought as a return of premium under any retrospective rating plan;

   c. Any amount due any reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries, as reinsurance recoveries, as contribution, as indemnification, or otherwise. A

claim under this subdivision for any amount due any reinsurer, insurer, insurance pool, or underwriting association may not be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in section 26.1-42.1-05;

d. Workers' compensation insurance, including any contract indemnifying an employer who pays compensation directly to employees;

e. Any first-party claim by an insured whose net worth exceeds ten million dollars on December thirty-first of the year immediately following the date the insurer becomes an insolvent insurer; provided that an insured's net worth on that date is deemed to include the aggregate net worth of the insured and all of the insured's subsidiaries as calculated on a consolidated basis; and

f. Any first-party claim by an insured that is an affiliate of the insolvent insurer.

6. "Insolvent insurer" means an insurer licensed to transact insurance in this state at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation was entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

7. "Member insurer" means any person, except a county mutual insurance company, that writes any kind of insurance to which this chapter applies under section 26.1-42.1-01, including the exchange of reciprocal or interinsurance contracts and that is licensed to transact insurance in this state. An insurer shall cease to be a member insurer on the day following the termination or expiration of the insurer's license to transact the kinds of insurance to which this chapter applies, however the insurer remains liable as a member insurer for every obligation, including an obligation for assessments levied before the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer before the termination or expiration of that insurer's license.

8. "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums on these policies and dividends paid or credited to policyholders on this direct business. The term does not include premiums on contracts between insurers or reinsurers.

26.1-42.1-03. Creation of the association. A nonprofit unincorporated legal entity known as the North Dakota insurance guaranty association is created. Every insurer defined as a member insurer in section 26.1-42.1-02 shall be and remain a member of the association as a condition of that insurer's authority to transact insurance in this state. The association shall perform association functions under a plan of operation established and approved under section 26.1-42.1-05 and shall exercise association powers through a board of directors established under section 26.1-42.1-04.

26.1-42.1-04. Board of directors.

1. The board of directors of the association consists of a minimum of five and a maximum of nine persons serving terms as established in the plan of operation. The members of the board must be selected by member insurers, subject to the approval of the commissioner. A vacancy on the board must be filled for the remaining period of the unexpired term by a majority vote of the remaining board members, subject to the approval of the commissioner. If the initial board members are not selected within sixty days after the effective date of this Act, the commissioner may appoint the initial members of the board.

2. In approving selections to the board, the commissioner shall consider at least whether all member insurers are fairly represented.

3. Every member of the board may be reimbursed from the assets of the association for expenses incurred by the member in the course of the member's official duties.

26.1-42.1-05. Powers and duties of the association.

1. The association:

   a. Shall pay covered claims existing before the order of liquidation and arising within thirty days after the order of liquidation or before the policy expiration date if less than thirty days after the order of liquidation, or before the insured replaces the policy or causes the policy's cancellation, if the insured does so within thirty days of the order of liquidation. The obligation must be satisfied by paying to the claimant an amount as follows:

      (1) An amount not exceeding ten thousand dollars per policy for a covered claim for the return of unearned premium.

      (2) An amount not exceeding three hundred thousand dollars per claim for all other covered claims.

   b. Is not obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provision of this chapter, a covered claim does not include a claim filed with the association after the earlier of eighteen months after the date of the order of liquidation or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer and a claim does not include any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred, but not reported, losses.

      Any obligation of the association to defend an insured on a covered claim ceases upon the association's payment, by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit or upon the association's tender of that amount.

Notwithstanding any other provision of this chapter, an obligation of the association to any person ceases when ten million dollars is paid in the aggregate by the association and any one or more associations similar to the association of any other state or states or any property and casualty security fund that obtains contributions from insurers on a preinsolvency basis, to or on behalf of any insured and the insured's affiliates on covered claims or allowed claims arising under the policy or policies of any one insolvent insurer. For purposes of this section, the term "affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person. If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association or any associations similar to the association or any property and casualty insurance security fund in other states, under the policy or policies of any one insolvent insurer, the association may establish a plan to allocate amounts payable by the association in any manner the association deems equitable.

c. Is deemed the insurer only to the extent of the association's obligation on the covered claims and to that extent, subject to the limitations provided in this chapter, has all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The association may not be deemed the insolvent insurer for any purpose relating to the issue of whether the association is amenable to the personal jurisdiction of the courts of any state.

d. Shall assess member insurer's amounts necessary to pay the obligations of the association under subdivision a following an insolvency, the expenses of handling covered claims following an insolvency and other expenses authorized by this chapter. The assessments of each member insurer must be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all members insurers for the calendar year preceding the assessment. Each member insurer must be notified of the assessment at least thirty days before the assessment is due. A member insurer may not be assessed in any one year an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available must be prorated and the unpaid portion must be paid as soon as funds become available. The association shall pay claims in any order the association determines reasonable, including the payment of claims as the claims are received from the claimants or in groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance;

provided, however, that during the period of deferment, dividends may not be paid to shareholders or policyholders. Deferred assessments must be paid when payment will not reduce capital or surplus below required minimums. Deferred assessment payments must be refunded to those companies receiving larger assessments by virtue of this deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of these claims by the member insurer.

e. Shall investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims. The association may review settlements, releases, and judgments to which the insolvent insurer or the insolvent insurer's insureds were parties to determine the extent to which these settlements, releases, and judgments may be properly contested. The association may appoint and direct legal counsel retained under liability insurance policies for the defense of covered claims.

f. Shall handle claims through the association's employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but this designation may be declined by a member insurer.

g. Shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this chapter.

2. The association may:

a. Employ or retain persons necessary to handle claims and perform other duties of the association;

b. Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

c. Sue or be sued, and this power to sue includes the power and right to intervene as a party before any court in this state which has jurisdiction over an insolvent insurer;

d. Negotiate and become a party to contracts that are necessary to carry out the purposes of this chapter;

e. Perform acts that are necessary or proper to effectuate the purpose of this chapter; and

f. Refund to the member insurers in proportion to the contribution of each member insurer that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities for the coming year as estimated by the board.

3. Except for actions by member insurers aggrieved by final actions or decisions by the association pursuant to subdivision h of subsection 3 of section 26.1-42.1-06, all claims for relief relating to this chapter against the association must be brought in the courts of this state. These courts have exclusive jurisdiction over all actions relating to this chapter against the association. Exclusive venue in any action by or against the association is in the district courts of this state. The association, at its option, may waive this exclusive venue as to specific actions.

26.1-42.1-06. Plan of operation.

1. The association shall submit to the commissioner a plan of operation and any amendments to this plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments become effective upon written approval by the commissioner. If the association fails to submit a suitable plan of operation within ninety days following the effective date of this Act, or if at any time after the effective date of this Act the association fails to submit suitable amendments to the plan, the commissioner, after notice and hearing, shall adopt rules as necessary or advisable to implement this chapter. These rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

2. All member insurers shall comply with the plan of operation.

3. The plan of operation must:

   a. Establish procedures by which all the powers and duties of the association under section 26.1-42.1-05 will be performed.

   b. Establish procedures for handling assets of the association.

   c. Establish procedures for the disposition of liquidating dividends or other moneys received from the estate of the insolvent insurer.

   d. Establish the amount and method of reimbursing members of the board of directors under section 26.1-42.1-04.

   e. Establish procedures by which claims may be filed with the association, if necessary, and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer are deemed notice to the association of the association's agent and periodically a list of claims must be submitted to the association or similar organization in another state by the receiver or liquidator.

   f. Establish regular places and times for meetings of the board of directors.

   g. Establish procedures for records to be kept of all financial transactions of the association, the association's agents and the board of directors.

h. Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty days after the action or decision.

i. Establish procedures by which selections for the board of directors will be submitted to the commissioner.

j. Contain provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that powers and duties of the association, except those under subdivision d of subsection 1 of section 26.1-42.1-05 and subdivision b of subsection 2 of section 26.1-42.1-05, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this association or this association's equivalent in two or more states. This corporation, association, or organization must be reimbursed as a servicing facility would be reimbursed and must be paid for performance of any other functions of the association. A delegation under this subsection takes effect only with the approval of the board of directors and the commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and less effective than that provided by this chapter.

26.1-42.1-07. Duties and powers of the commissioner.

1. The commissioner shall:

a. Notify the association of the existence of an insolvent insurer within three days after the commissioner receives notice of the determination of the insolvency. The association is entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that this complaint is filed with a court of competent jurisdiction.

b. Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

2. The commissioner may:

a. Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. In the alternative, the commissioner may levy a fine on any member insurer that fails to pay an assessment when due. A fine under this subdivision may not exceed five percent of the unpaid assessment per month, except that a fine may not be less than one hundred dollars per month.

b. Revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

26.1-42.1-08. Effect of paid claims.

1. Any person recovering under this chapter is deemed to have assigned that person's rights under the policy to the association to the extent of recovery from the association. Every insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent as that insured or claimant would have been required to cooperate with the insolvent insurer. The association does not have a claim for relief against the insured of the insolvent insurer for any sums the association paid out except for claims for relief the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in subsection 2. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association do not reduce the liability of the insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

2. The association may recover from the following persons the amount of any covered claim paid on behalf of that person pursuant to this chapter:

   a. Any insured whose net worth on December thirty-first of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds twenty-five million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter;

   b. Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter; and

   c. Any insured who is not a resident of this state at the time of the insured event, except for first-party covered claims for property damage to an insured's property that is permanently located in this state.

3. The association any any similar organization in another state are recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by the association or similar organization on covered claims obligations as determined under this chapter or similar laws in other states and receive dividends and any other distributions at the priority set forth in section 26.1-06.1-41. The receiver, liquidator, or statutory successor of an insolvent insurer is bound by determinations of covered claim eligibility under this chapter and by settlements of claims made by the association or a similar organization in another state. The court with jurisdiction shall grant these claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer.

4. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which preserve the rights of the association against the assets of the insolvent insurer.

26.1-42.1-09. Exhaustion of other coverage.

1. Any person with a claim against an insurer, regardless of whether that insurer is a member insurer under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, is required to exhaust first that person's right under that policy. Any amount payable on a covered claim under this chapter must be reduced by the amount of any recovery under the insurance policy.

2. Any person with a claim that may be recovered under more than one insurance guaranty association or equivalent shall seek recovery first from the association of the place of residence of the insured except that if the claim is a first-party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. Any recovery under this chapter must be reduced by the amount of recovery from any other insurance guaranty association or equivalent.

26.1-42.1-10. Prevention of insolvencies. To aid in the detection and prevention of insurer insolvencies:

1. The board of directors, upon majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

2. The board of directors, upon majority vote, may make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

3. The board of directors, at the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, may prepare a report on the history and causes of the insolvency, based on the information available to the association and submit this report to the commissioner.

26.1-42.1-11. Examination of the association. The association is subject to examination and regulation by the commissioner. The board of directors shall submit, by March thirty-first of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

26.1-42.1-12. Tax exemption. The association is exempt from payment of all fees and all taxes levied by this state or any political subdivision except taxes levied on property.

26.1-42.1-13. Recognition of assessments in rates. The rate and premiums charged for insurance policies to which this chapter applies must include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. These rates may not be determined to be excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

26.1-42.1-14. Immunity. There is no liability on the part of and no claim for relief may arise against any member insurer, the association or the association's agents or employees, the board of directors, or any person serving as a representative of any director, or the commissioner or the commissioner's

representatives for any action taken or any failure to act by these entities in the performance of their powers and duties under this chapter.

26.1-42.1-15. Stay of proceedings. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state, subject to waiver by the association in specific cases involving covered claims, must be stayed until the last day fixed by the court for the filing of claims and additional time after this as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or the insolvent insurer's failure to defend an insured, the association on its own behalf or on behalf of such insured may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and may defend the claim on the merits. The liquidator, receiver, or statutory successor of an insolvent insurer covered by this chapter shall permit access by the board or the board's authorized representative to the insolvent insurer's records that are necessary for the board in carrying out the board's functions under this chapter with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board or the board's representative with copies of these records upon the request by the board and at the expense of the board.

SECTION 7. AMENDMENT. Subsection 3 of section 26.1-46-04 of the North Dakota Century Code is amended and reenacted as follows:

3. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state may be covered by the state guaranty fund subject to chapter ~~26.1-42~~ 26.1-42.1.

SECTION 8. REPEAL. Chapter 26.1-42 of the North Dakota Century Code is repealed.

Approved March 5, 1999
Filed March 5, 1999

CHAPTER 260

HOUSE BILL NO. 1238
(Representative Klemin)

MUTUAL INSURANCE COMPANY BYLAWS AND VOTING AND EXEMPTIONS FROM PROCESS

AN ACT to amend and reenact sections 26.1-12-06, 26.1-12-14, 26.1-12-16, and subsection 3 of section 28-22-03.1 of the North Dakota Century Code, relating to mutual insurance company bylaws, domestic mutual insurance company voting, and absolute exemptions of Roth individual retirement accounts in process, levy, and sale proceedings.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[193] **SECTION 1. AMENDMENT.** Section 26.1-12-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-06. Bylaws of mutual company - Meetings - Notice - Quorum. The bylaws of any mutual insurance company organized under this chapter or chapter 26.1-05 must prescribe the manner of notification to members of all corporation meetings of members and must prescribe what constitutes a quorum of members. A quorum is those members present in person or represented by written proxies. A majority of those voting is sufficient to approve or reject any proposal submitted at any annual or special meeting. Every member of the company is entitled to one vote only. Every member must be notified of the time and place of the holding of the meetings of the company by a written notice or by an imprint on ~~the back of~~ each policy, receipt, or certificate of renewal. In addition, a notice of any annual or special meeting must be published in the official newspaper of the county in which the principal office of the company is located. The notice must be published at least twice, the first publication to be made at least sixty days before the meeting. If a special meeting of members is called, a notice of the time, place, and object of the meeting must be mailed to all members at least sixty days before the meeting.

SECTION 2. AMENDMENT. Section 26.1-12-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-14. Membership in domestic mutual company - Votes of members - Notice of meetings. Every member i~~nsured by~~ of a domestic mutual insurance company organized under this chapter is a member of the company while the policy is in force. A member may be an insured or owner of a policy as provided in the bylaws of the company. Every member of the company is entitled to one vote ~~or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws of the company~~. Every member must be notified of the time and place of the holding of the meetings of the company by a written notice or by an imprint on ~~the back of~~ each policy, receipt, or certificate of renewal as follows:

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[193] Section 26.1-12-06 was also amended by section 5 of House Bill No. 1175, chapter 254.

The ~~assured~~ member is hereby notified that by virtue of this policy ~~the assured~~ ~~is~~ you are a member of _____ mutual insurance company, and that the annual meetings of such company are held at its home office on the _____ day of _____ in each year at _____ o'clock.

When the blanks in the notice are properly filled, the notice is sufficient.

SECTION 3. AMENDMENT. Section 26.1-12-16 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-16. Vote by proxy permitted - Manner of voting by proxy. Members of a mutual insurance company may vote by proxy dated and executed within three months prior to the meeting at which the proxy is to be used when returned and recorded on the books of the company three days or more before the meeting. A person may not as proxy or otherwise cast more than fifty votes, and an officer, personally or by another, may not ask for, receive, procure to be obtained, or use, a proxy vote. This section does not apply to ~~state mutual hail insurance companies~~ a proxy committee duly established by the bylaws comprised of no less than three members appointed by the board of directors whose duty is to cast the vote by proxy of members at any duly called annual or special meeting of the mutual insurance company.

[194] **SECTION 4. AMENDMENT.** Subsection 3 of section 28-22-03.1 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

3. Pensions, annuity policies or plans, and life insurance policies which, upon the death of the insured, would be payable to the spouse, children, or any relative of the insured dependent, or likely to be dependent, upon the insured for support and which have been in effect for a period of at least one year; individual retirement accounts; Keogh plans, Roth individual retirement accounts under section 408A of the Internal Revenue Code [Pub. L. 105-34; 111 Stat. 825; 26 U.S.C. 408A], and simplified employee pension plans; and all other plans qualified under section 401 of the Internal Revenue Code [Pub. L. 83-591; 68A Stat. 134; 26 U.S.C. 401], and section 408 of the Internal Revenue Code [Pub. L. 93-406; 88 Stat. 959; 26 U.S.C. 408], and pension or retirement plans sponsored by nonprofit corporations or associations organized and operated exclusively for one or more of the purposes specified in 26 U.S.C. 501(c)(3), and proceeds, surrender values, payments, and withdrawals from such pensions, policies, plans, and accounts, up to one hundred thousand dollars for each pension, policy, plan, and account with an aggregate limitation of two hundred thousand dollars for all pensions, policies, plans, and accounts. The dollar limit does not apply to the extent this property is reasonably necessary for the support of the resident and that resident's dependents, except that the pensions, policies, plans, and accounts or proceeds, surrender values, payments, and withdrawals are not exempt from enforcement of any order to pay spousal support or child support, or a qualified domestic relations order under sections 15-39.1-12.2, 39-03.1-14.2, and 54-52-17.6. As used in

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[194] Section 28-22-03.1 was also amended by section 1 of Senate Bill No. 2241, chapter 285.

this subsection, "reasonably necessary for the support" means required to meet present and future needs, as determined by the court after consideration of the resident's responsibilities and all the present and anticipated property and income of the resident, including that which is exempt.

Approved March 11, 1999
Filed March 11, 1999

CHAPTER 261

SENATE BILL NO. 2221

(Senator Mutch)
(Representative Berg)

MUTUAL INSURANCE COMPANIES

AN ACT to create and enact three new sections to chapter 26.1-12.1 of the North Dakota Century Code, relating to foreign mutual insurance holding companies; and to amend and reenact sections 26.1-12.1-01 and 26.1-12.1-09 of the North Dakota Century Code, relating to definitions and approval of a reorganization by eligible members of a domestic mutual insurance company.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-12.1-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-12.1-01. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Commissioner" means the commissioner of insurance.

2. "Domestic mutual insurance company" or "mutual insurance company" means a mutual insurance company incorporated under the laws of this state pursuant to chapter 26.1-12 or other prior provisions of this title.

3. "Domestic mutual insurance holding company" or "mutual insurance holding company" means a company formed under section 26.1-12.1-02.

4. "Eligible member" means a policyholder whose policy is in force as of the record date or member as defined under the bylaws or articles of incorporation of the reorganizing insurer. Unless otherwise provided in the reorganization plan, a person insured under a certificate issued under a group policy is not an eligible member.

5. "Foreign mutual insurance company" means a mutual insurance company incorporated under the laws of another state.

6. "Foreign mutual insurance holding company" means a company formed under provisions of the laws of another state similar to those contained in this chapter.

~~3.~~ 7. "Membership interest" means all interests of eligible members of the reorganizing insurer, including rights to vote and to participate in any distribution of surplus, whether or not incident to the company's liquidation. It does not include the contractual rights remaining with the reorganized insurance company.

~~4. "Mutual insurance company" means a mutual insurance company incorporated under the laws of this state pursuant to chapter 26.1-12 or other prior provisions of this title.~~

~~5. "Mutual insurance holding company" means a company formed under section 26.1-12.1-02.~~

~~6.~~ 8. "Plan of reorganization" means a plan to engage or participate in a reorganization subject to this chapter.

~~7.~~ 9. "Policy" means a policy or contract of insurance issued by a mutual insurance company, including an annuity contract.

~~8.~~ 10. "Record date" means the date the reorganizing insurer's board of directors adopts a plan of reorganization or some other date specified as the record date in the plan of reorganization and approved by the commissioner.

~~9.~~ 11. "Reorganization" means any plan or transaction described in section 26.1-12.1-02 or 26.1-12.1-03, or section 3 of this Act, or any change in the reorganized insurer's articles of incorporation or bylaws which is a material change to the plan of reorganization filed and approved by the commissioner affecting the ability of the reorganizing insurer to meet the standards described in section 26.1-12.1-06.

~~10.~~ 12. "Reorganized insurance company" means a mutual insurance company that has completed a reorganization to a stock company that is subject to this chapter. A domestic or foreign mutual insurance company that has completed a reorganization to a stock company may retain the word "mutual" in its name so long as it is clearly identified with its name that it is a stock insurance subsidiary of a domestic or foreign mutual insurance holding company.

~~11.~~ 13. "Reorganizing insurer" means a mutual insurance company, whether domestic or foreign, seeking to participate, or participating, in merger or other reorganization as defined in this chapter.

SECTION 2. AMENDMENT. Section 26.1-12.1-09 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-12.1-09. Approval by eligible members. The plan of reorganization must be adopted upon receiving the affirmative vote of a majority of the votes cast by eligible members. Eligible members may vote in person or by proxy. The form of any proxy along with a copy or summary of the plan which accompanied the notice to eligible members must be filed with and approved by the commissioner. The number of votes each eligible member may cast must be determined by the ~~converting~~ reorganizing ~~insurer's~~ domestic mutual insurance company's bylaws. If the bylaws are silent, each eligible member may cast one vote. The plan must be approved as follows:

1. In the case of formation of a mutual insurance holding company under section 26.1-12.1-02, the reorganization plan must be approved by the affirmative vote of a majority of the votes cast by no less than ten percent of the eligible members of the reorganizing ~~insurer~~ domestic mutual insurance company; and

2. In the case of a merger under section 26.1-12.1-03, the reorganization plan must be approved by an affirmative vote of a majority of the votes cast by no less than ten percent of the eligible members of the reorganizing ~~insurer~~ domestic mutual insurance company and by an

affirmative vote of a majority of the votes cast by no less than ten percent of the eligible members of the mutual insurance holding company into which the policyholders' membership interests are to be merged, provided that the vote of the eligible members of the mutual insurance holding company may not be required if the commissioner determines that the merger would not be material to the financial condition of the mutual insurance holding company.

SECTION 3. Three new sections to chapter 26.1-12.1 of the North Dakota Century Code are created and enacted as follows:

Foreign mutual insurance holding company - Reorganization. A domestic mutual insurance company may reorganize with a foreign mutual insurance holding company that is created or exists under the laws of another state by complying with chapter 26.1-12.1. The commissioner may waive any provision of chapter 26.1-12.1 if the commissioner determines the provision to be unnecessary for the protection of eligible members.

A plan of reorganization under this section must comply with the requirements and standards of section 26.1-12.1-06 and be approved by the eligible members of the domestic mutual insurance company as a reorganizing insurer in accordance with subsection 1 of section 26.1-12.1-09. A domestic mutual insurance company seeking to reorganize under this section may at the same time redomesticate to another state by complying with section 26.1-05-07.3 and the applicable requirements of the state to which it seeks to transfer domicile.

Existing domestic mutual insurance holding company - Reorganization. An existing domestic mutual insurance holding company, with the prior approval of the commissioner pursuant to, and under the provisions of section 26.1-12.1-06, may:

1. Acquire direct or indirect ownership of a foreign mutual insurance company as a reorganizing insurer in compliance with the laws of its state of domicile; and

2. Grant membership interest and equity rights in the domestic mutual insurance holding company to eligible members of a foreign mutual insurance company as a reorganizing insurer that merges with a direct or indirect domestic or foreign subsidiary of the domestic mutual insurance holding company, or is otherwise acquired by the domestic mutual insurance holding company.

The commissioner shall consider the fairness of the terms and conditions of the transaction, whether the interests of the eligible members of the domestic mutual insurance holding company that is a party to the transaction are protected in accordance with this chapter. A plan of reorganization under this section must be approved by the eligible members of the domestic mutual insurance holding company in accordance with subsection 2 of section 26.1-12.1-09.

Concurrent reorganization - Domestic or foreign. The concurrent reorganization of a domestic mutual insurance company with one or more mutual insurance companies, whether domestic or foreign, into a single mutual insurance holding company structure, whether domestic or foreign, may be accomplished by a joint application and a joint plan of reorganization and may be approved by complying with the requirements and standards of section 26.1-12.1-06 by the commissioner following a hearing as provided for in this chapter. The commissioner may allow such other procedures to avoid unnecessary or duplicative costs and efforts in satisfying the requirements of this chapter and effectuating the reorganization.

Approved March 15, 1999
Filed March 15, 1999

CHAPTER 262

SENATE BILL NO. 2295

(Senator W. Stenehjem)

INSURANCE COMPANY MEDICARE CLAIM ADMINISTRATION

AN ACT to amend and reenact subsection 5 of section 26.1-17-33.1 of the North Dakota Century Code, relating to formation of insurance companies for administration of medicare claims.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 5 of section 26.1-17-33.1 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

5. A nonprofit mutual insurance company may form a stock i~~nsurance~~ company for the purpose of administering medicare claims.

Approved March 15, 1999
Filed March 15, 1999

CHAPTER 263

SENATE BILL NO. 2407

(Senators D. Mathern, Flakoll)

RENTAL CAR AGENCY INSURANCE SALES

AN ACT to create and enact a new section to chapter 26.1-26 of the North Dakota Century Code, relating to insurance sales by rental car agencies.

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:

Insurance license for automobile rental agencies - Exception. A license as an insurance agent or limited insurance representative is not required for the counter sales personnel of an automobile rental company or its franchisee if:

1. The automobile rental company is appropriately licensed in this state under section 26.1-26-08 or is affiliated with an appropriately licensed North Dakota agent.

2. The coverage offered by the counter sales personnel is limited to the following:

   a. Personal accident insurance covering the risks of travel, including accident and health insurance that provides coverage to renters and other rental vehicle occupants for accidental death or dismemberment and for medical expenses resulting from an accident that occurs during the rental period;

   b. Supplemental liability insurance that must include uninsured and underinsured motorist coverage, either offered separately or in combination with other liability insurance, and that provides coverage to renters and other authorized drivers for liability arising from the operation of the rental vehicle;

   c. Personal effects insurance that provides coverage to renters and other vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period;

   d. Roadside assistance and emergency sickness protection programs; and

   e. Any other coverage that a rental company offers in connection with and incidental to the rental of vehicles.

3. The rental period is ninety days or less.

4. The automobile rental company files an acknowledgement with the commissioner that its counter sales personnel act on its behalf and that it is responsible for any representations made by the counter sales personnel relating to insurance products offered through the automobile

rental company or its franchisee. The acknowledgement must state that the commissioner has the right to take any administrative action contemplated in this title, including revocation or suspension of the license required under subsection 1.

5. The automobile rental company provides basic training to counter sales personnel in the insurance products offered under this section. The training must require counter sales personnel to refer all customers with questions regarding the insurance products offered under this section to appropriately licensed agents employed by the automobile rental company or to written brochures or other materials that:

   a. Summarize the material terms of the coverage, including the identity of the insurer;

   b. Disclose that the policies offered by the automobile rental company may duplicate coverage already provided by other insurance the renter may have;

   c. State that the purchase of insurance is not required to rent the vehicle; and

   d. Describes the process of filing a claim.

6. The counter sales personnel are not directly paid by an insurance company, a commission, or any other compensation for the sale of insurance. Nothing in this section prevents the automobile rental company from including the insurance products in an overall employee performance compensation incentive program.

Approved March 19, 1999
Filed March 19, 1999

CHAPTER 264

HOUSE BILL NO. 1136

(Human Services Committee)
(At the request of the State Board of Medical Examiners)

UTILIZATION REVIEW DETERMINATIONS

AN ACT to create and enact a new section to chapter 65-02 of the North Dakota Century Code, relating to managed care for workers' compensation; to amend and reenact subsection 4 of section 26.1-26.4-02 and subsection 8 of section 26.1-26.4-04 of the North Dakota Century Code, relating to the definition of utilization review and to minimum standards of utilization review agents; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 4 of section 26.1-26.4-02 of the North Dakota Century Code is amended and reenacted as follows:

4. "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

[195] **SECTION 2. AMENDMENT.** Subsection 8 of section 26.1-26.4-04 of the North Dakota Century Code is amended and reenacted as follows:

8. ~~Physicians or psychologists~~ Psychologists making utilization review determinations shall have current licenses from ~~a state licensing agency in the United States~~ the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

SECTION 3. A new section to chapter 65-02 of the North Dakota Century Code is created and enacted as follows:

Licensure required for psychologists and physicians performing utilization review. Psychologists making utilization review determinations under sections 65-02-20 and 65-02-21 shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations under 65-02-20 and 65-02-21 shall have current licenses from the state board of medical examiners. This requirement does not apply to psychologists or physicians conducting independent medical examinations under section 65-05-28.

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[195] Section 26.1-26.4-04 was also amended by section 4 of Senate Bill No. 2400, chapter 257.

SECTION 4. EFFECTIVE DATE. Section 2 of this Act becomes effective on August 1, 2000.

Approved March 25, 1999
Filed March 25, 1999

CHAPTER 265

HOUSE BILL NO. 1396
(Representative R. Kelsch)

MENTAL DISORDERS COVERAGE

AN ACT to amend and reenact section 26.1-36-09 of the North Dakota Century Code, relating to insurance coverage for treatment of mental disorders.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[196] **SECTION 1. AMENDMENT.** Section 26.1-36-09 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09. Group health policy and health service contract mental disorder coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental disorder and other related illness, which benefits meet or exceed the benefits provided in subsection 2.

2. a. The benefits must be provided for each of the following services: inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment.

   b. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of ~~sixty~~ forty-five 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~~ under section 52-01-01 and rules of the state department of health pursuant thereto offering treatment for the prevention or cure of mental disorder or other related illness. An insurance provider may require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community.

   c. In the case of benefits provided for partial hospitalization ~~or~~ ~~residential~~ ~~treatment~~, 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~~. Partial

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[196] Section 26.1-36-09 was also amended by section 1 of Senate Bill No. 2213, chapter 266.

hospitalization must be provided by a hospital as defined ~~in subsection 25 of~~ under section 52-01-01 and rules of the state department of health 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~~, or by a residential treatment program~~. 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 must be provided for a combination of inpatient hospitalization, partial hospitalization, and residential treatment~~ In the case of benefits provided for residential treatment, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section in any calendar year. Residential treatment services must be provided by a hospital as defined under section 52-01-01 and rules of the state department of health; 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; or by a residential treatment program. For services provided in a regional human service center, charges must be reasonably similar to the charges for care provided by a hospital as defined in this subsection.

e. Any individual receiving residential treatment services who requires residential treatment service beyond the minimum of one hundred twenty days may trade unused patient treatment benefits provided for under subdivision b. 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 or~~ a residential treatment program; provided, however, that no more than ~~forty-six~~ twenty-three days of the inpatient treatment benefits required by this section may be traded for t~~reatment by partial hospitalization or~~ residential treatment services.

~~e.~~ f. (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 independent clinical social worker.

(2) A person who is qualified for third-party payment by the board of social work examiners on August 1, 1997, is exempt from paragraph 1.

(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.

(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.

(5) 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.

~~f.~~ g. "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.

~~g.~~ h. "Residential treatment" has the same meaning as provided in section 25-03.2-01; but only applies to individuals under twenty-one years of age.

3. This section does not prevent any insurance company, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, where the policy or contract is not subject to such provisions.

Approved April 7, 1999
Filed April 8, 1999

CHAPTER 266

SENATE BILL NO. 2213

(Senators DeMers, W. Stenehjem, Watne)
(Representatives Gulleson, Svedjan, Price)

MENTAL HEALTH TREATMENT COVERAGE

AN ACT to amend and reenact paragraph 1 of subdivision e of subsection 2 of section 26.1-36-09 of the North Dakota Century Code, relating to group insurance coverage for licensed professional clinical counselors providing outpatient mental health treatment.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[197] **SECTION 1. AMENDMENT.** Paragraph 1 of subdivision e of subsection 2 of section 26.1-36-09 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

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, a licensed professional clinical counselor who is qualified in the clinical mental health counseling specialty in this state, or a licensed independent clinical social worker.

Approved March 18, 1999
Filed March 19, 1999

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[197] Section 26.1-36-09 was also amended by section 1 of House Bill No. 1396, chapter 265.

CHAPTER 267

HOUSE BILL NO. 1297

(Representatives Sandvig, Rose, Wentz)
(Senators DeMers, Krauter, Thane)

MAMMOGRAM COVERAGE

AN ACT to amend and reenact sections 26.1-36-09.1 and 54-52.1-04.4 of the North Dakota Century Code, relating to health insurance and public employee retirement system coverage of mammograms.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-09.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.1. Health insurance policy and health service contract - Mammogram examination coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

   a. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

   b. One mammogram examination every ~~two~~ ~~years~~ year, or more frequently if ordered by a physician, for ~~women~~ each woman who ~~are~~ is at least forty ~~but~~ l~~ess~~ ~~than~~ ~~fifty~~ years of age.

   ~~c. One mammogram examination every year for women age fifty and over.~~

2. This section does not apply to individually guaranteed renewable supplemental, specified disease, long-term care, or other limited benefit policies.

SECTION 2. AMENDMENT. Section 54-52.1-04.4 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.4. Insurance to cover mammogram examinations. The board shall provide medical benefits 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:

1. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

2. One mammogram examination every ~~two~~ ~~years~~ year, or more frequently if ordered by a physician, for ~~women~~ each woman who ~~are~~ is at least forty ~~but~~ l~~ess~~ ~~than~~ ~~fifty~~ years of age.

~~3. One mammogram examination every year for women age fifty and over.~~

Approved March 31, 1999
Filed March 31, 1999

CHAPTER 268

SENATE BILL NO. 2374

(Senators W. Stenehjem, Lee, Thane)
(Representatives Delmore, Kliniske, Poolman)

FOOD FOR INHERITED METABOLIC DISEASE COVERAGE

AN ACT to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to insurance coverage of foods and food products for inherited metabolic diseases; and to amend and reenact section 26.1-36-09.7 of the North Dakota Century Code, relating to removal of the sunset provision of the foods and food products for inherited metabolic diseases insurance coverage law.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-09.7 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.7. ~~(Effective through July 31, 1999)~~ Foods and food products for inherited metabolic diseases.

1. As used in this section:

   a. "Inherited metabolic disease" means maple syrup urine disease or phenylketonuria.

   b. "Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.

   c. "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a physician.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prescription coverage on an individual, group, blanket, franchise, or association basis, unless the policy or contract provides, for any person covered under the policy or contract, coverage for medical foods and low protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease.

3. This section applies to any covered individual born after December 31, 1962. This section does not require coverage for low protein modified

food products in excess of three thousand dollars per year for an individual with an inherited metabolic disease of amino acid or organic acid.

4. This section does not require medical benefits coverage for low protein modified food products or medical food for an individual to the extent those benefits are available to that individual under a department of health program.

SECTION 2. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Insurance to cover foods and food products for inherited metabolic diseases. The board shall provide medical benefits coverage under 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 foods and food products for inherited metabolic diseases in the same manner as provided for under section 26.1-36-09.7.

Approved April 1, 1999
Filed April 2, 1999

CHAPTER 269

HOUSE BILL NO. 1452
(Representative Sveen)

DENTAL ANESTHESIA AND HOSPITALIZATION COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to required insurance coverage for dental anesthesia and hospitalization.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Dental anesthesia and hospitalization coverage. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits for anesthesia and hospitalization for dental care provided to a covered individual who is a child under age nine, is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. A carrier may require preauthorization of hospitalization for dental care procedures under this section in the same manner preauthorization is required for hospitalization for other covered diseases or conditions. Coverage under this section applies regardless of whether the services are provided in a hospital or an ambulatory surgery center.

SECTION 2. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Insurance to cover dental anesthesia and hospitalization. The board shall provide medical benefits coverage under 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 dental anesthesia and hospitalization in the same manner as provided under section 1 of this Act.

Approved March 25, 1999
Filed March 25, 1999

CHAPTER 270

HOUSE BILL NO. 1039

(Legislative Council)
(Insurance and Health Care Committee)

AMBULANCE SERVICES COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to insurance coverage of ambulance services for prehospital emergency medical services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance policy and health service contract - Prehospital emergency medical services.

1. In this section, unless the context or subject matter otherwise requires:

   a. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part.

   b. "Prehospital emergency medical services" means a service or its personnel either licensed under chapter 23-27 or certified by the state health department.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prehospital emergency medical services benefits on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides prehospital emergency medical services benefits in the case of an emergency medical condition.

3. The coverage required under this section does not require coverage in excess of policy aggregate limits or internal policy limits dealing specifically with prehospital emergency medical services.

4. This section does not prevent an insurance company, nonprofit health service corporation, or health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for prehospital emergency medical services.

Approved April 7, 1999
Filed April 8, 1999

CHAPTER 271

SENATE BILL NO. 2251
(Senator Grindberg)

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

26.1-38.1-01. Scope.

1. This section provides coverage for the policies and contracts specified in subsection 2:

   a. To persons, except for nonresident certificate holders under group policies or contracts, who, regardless of where they reside, are the beneficiaries, assignees, or payees of the persons covered under subdivision b~~; and~~.

   b. To persons who are owners of or certificate holders under such policies or contracts~~; or, in the case of~~ other than unallocated annuity contracts~~; to the persons who are contractholders;~~ and structured settlement annuities, and in each case who

      (1) Are residents; or

      (2) Are not residents, but only under all of the following conditions:

         (a) The i~~nsurers~~ insurer that issued such policies or contracts ~~are~~ is domiciled in this state;

         (b) ~~Such~~ i~~nsurers never held~~ a l~~icense or certificate of authority in the~~ states ~~in which such persons reside~~ The states in which the persons reside have associations similar to the association created under this chapter;

         (c) ~~Such states have associations similar to the association created by this chapter; and~~

         ~~(d)~~ ~~Such~~ The persons are not eligible for coverage by ~~such associations~~ an association in any other state due to the

fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

c. For any unallocated annuity contract specified in subsection 2, subdivisions a and b of this subsection do not apply, and this chapter, except as provided in subdivisions e and f of this subsection, provides coverage to:

(1) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan, the sponsor of which has its principal place of business in this state; and

(2) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

d. For structured settlement annuities specified in subsection 2, subdivisions a and b of this subsection do not apply, and this chapter, except as provided in subdivisions e and f, provides coverage to a person who is a payee under a structured settlement annuity or beneficiary of a payee if the payee is deceased, if the payee:

(1) Is a resident, regardless of where the contract owner resides; or

(2) Is not a resident, and:

(a) The contractowner of the structured settlement annuity is a resident, or the contractowner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contractowner resides has an association similar to the association created under this chapter; and

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

e. This chapter does not provide coverage to:

(1) A person who is a payee or beneficiary of a contractowner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

(2) A person covered under subdivision b, if any coverage is provided by the association of another state to the person.

f. This chapter provides coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. In determining the application of the provisions of this

subdivision in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this chapter must be construed in conjunction with other state laws to result in coverage by only one association.

2. This chapter provides coverage to the persons specified in subsection 1 for direct, nongroup life, health, or annuity~~, and supplemental~~ policies or contracts, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, structured settlement a~~greements, lottery contracts~~ annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

3. This chapter does not provide coverage for:

   a. Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner;

   b. Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

   c. Any portion of a policy or contract to the extent that the rate of interest on which it is based:

      (1) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

      (2) On and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

   d. ~~Any~~ A portion of a policy or contract issued to a plan or program of an employer, association, or ~~similar entity~~ other person to provide life, health, or annuity benefits to its employees ~~or~~, members, or others, to the extent that such plan or program is self-funded or uninsured including benefits payable by an employer association or ~~similar entity~~ other person under:

      (1) A multiple employer welfare arrangement as defined in ~~section 514 of the Employee Retirement Income Security Act of 1974, as amended~~ 29 U.S.C. section 1144;

      (2) A minimum premium group insurance plan;

(3) A stop-loss group insurance plan; or

(4) An administrative services only contract;

e. Any portion of a policy or contract to the extent that it provides for dividends or experience rating credits, voting rights, or ~~provides that~~ payment of any fees or allowances ~~be paid~~ to any person, including the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner, in connection with the service to or administration of such policy or contract;

f. Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

g. Any unallocated annuity contract issued to ~~an employee~~ or in connection with a benefit plan protected under the federal pension benefit guaranty corporation regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan; ~~and~~

h. Any portion of any unallocated annuity contract which is not issued to, or in connection with, a specific employee, union, or association~~, or~~ of natural persons benefit plan or a government lottery;

i. A portion of a policy or contract to the extent that the assessments required by section 26.1-38.1-06 with respect to the policy or contract are preempted by federal or state law;

j. An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contractowner or policyowner, including:

(1) Claims based on marketing materials;

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

(3) Misrepresentations of or regarding policy benefits;

(4) Extracontractual claims; or

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

k. A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

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

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

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

(1) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(2) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values; or

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

c. With respect to each individual participating in a government retirement benefit plan established under section 401(k), 403(b), or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, one hundred thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values; ~~provided, however, that in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one individual under this subdivision and subdivision b; or~~

d. With respect to ~~any one contractholder covered by an unallocated annuity contract not included in subdivision b, five million dollars in benefits, irrespective of the number of such contracts held by that contractholder.~~ each payee of a structured settlement annuity or beneficiary, or beneficiaries of the payee if deceased, one hundred thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

e. With respect to one contractowner provided coverage under subparagraph d of paragraph 2 of subdivision b of subsection 1; or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subdivision c, five million dollars in benefits, irrespective of the number of contracts with respect to the contractowner or plan sponsor. However, in the case in which one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage must be afforded by the association if the largest interest in the trust or entity owning the contracts or contracts is held by a plan sponsor whose principal place of business is in this state and in no event is the association obligated to cover more than five million dollars in benefits with respect to all these unallocated contracts.

5. However, under subsection 4 in no event shall the association be obligated to cover more than an aggregate of three hundred thousand dollars in benefits with respect to any one life under subdivision b of

subsection 4, or with respect to one owner of multiple nongroup policies of life insurance, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner.

6. The limitations set forth in subsection 4 are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

7. In performing its obligations to provide coverage under this chapter, the association is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

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

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

1. "Account" means either of the two accounts created under section 26.1-38.1-03.

2. "Association" means the North Dakota life and health insurance guaranty association created under section 26.1-38.1-03.

3. "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed under which an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

4. "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

5. "Called assessment" or "called" when used in the context of assessments means that a notice was issued by the association to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

6. "Commissioner" means the insurance commissioner ~~of insurance~~ of this state.

~~4.~~ 7. "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 26.1-38.1-01.

~~5.~~ 8. "Covered policy" means any policy or contract ~~within the scope of~~ or portion of a policy or contract for which coverage is provided under this chapter ~~under section 26.1-38.1-01~~.

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

~~6.~~ 10. "Impaired insurer" means a member insurer ~~which~~ that, after July 1, 1989, is not an insolvent insurer, and ~~is deemed by the commissioner to be potentially unable to fulfill its contractual obligations or~~ is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

~~7.~~ 11. "Insolvent insurer" means a member insurer which, after July 1, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

~~8.~~ 12. "Member insurer" means any insurer, including a nonprofit health service corporation, licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 26.1-38.1-01, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

a. A health maintenance organization;

b. A fraternal benefit society;

c. A mandatory state pooling plan;

d. A mutual assessment company or ~~any entity~~ other person that operates on an assessment basis;

e. A nonprofit health service corporation that is participating in a reinsurance plan that has been approved by the commissioner as an alternative to participation in the state guaranty association;

f. An insurance exchange; or

g. Any entity similar to any of the above.

~~9.~~ 13. "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, incorporated, or any successor thereto.

14. "Owner" of a policy or contract and "policyowner" and "contractowner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contractowner, and policyowner do not include persons with a mere beneficial interest in a policy or contract.

~~10.~~ 15. "Person" means any individual, corporation, limited liability company, partnership, association, governmental entity, or voluntary organization.

16. "Plan sponsor" means:

a. The employer in the case of a benefit plan established or maintained by a single employer;

b. The employee organization in the case of a benefit plan established or maintained by an employee organization; or

c. In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

~~11.~~ 17. "Premiums" means amounts or considerations, by whatever named called, received in any calendar year on covered policies or contracts less returned premiums, considerations, and deposits ~~returned~~ ~~thereon~~, and less dividends and experience credits ~~thereon~~. "Premiums" do not include any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsections 2 and 3 of section 26.1-38.1-01 and except that assessable premium shall not be reduced on account of subdivision c of subsection 3 of section 26.1-38.1-01, relating to interest limitations, and subsection 3 of section 26.1-38.1-01, relating to limitations with respect to any one individual, any one participant, and any one ~~contractholder;~~ ~~provided~~ ~~that~~ ~~"premiums"~~ ~~do~~ contractowner. "Premiums" do not include ~~any~~ ~~premiums~~:

a. Premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under section 401(k), 403(b), or 457 of the United States Internal Revenue Code; or

b. With respect to multiple nongroup policies of life insurance owned by one owner, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

18. "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the nature persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the state in which the primary executive and administrative headquarters of the entity is located; in which the principal office of the chief executive officer of the entity is located; in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; from which the management of the overall operations of the entity is directed; and in the case of a benefit plan

sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty-percent of the participants in the benefit plan are employed in a single state, that state is deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subdivision c of subsection 16 is deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

19. "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conversation, rehabilitation, or liquidation of the insurer.

~~12.~~ 20. "Resident" means any person to whom a contractual obligation is owed and who resides in this state ~~at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed~~ on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person must be its principal place of business. Citizens of the United States who are residents of foreign countries, or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created under this chapter, are deemed residents of the state of domicile of the insurer that issued the policies or contracts.

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

22. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

~~13.~~ 23. "Supplemental contract" means any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract ~~proceeds~~.

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

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

26.1-38.1-03. Creation of the association.

1. There is created a nonprofit legal entity to be known as the North Dakota life and health insurance guaranty association. All member insurers must be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 26.1-38.1-07 and shall exercise its powers through a board of directors established under section 26.1-38.1-04. For purposes of administration and assessment, the association shall maintain two accounts:

   a. The life insurance and annuity account ~~which~~ that includes the following subaccounts:

      (1) Life insurance account;

      (2) Annuity account, which includes annuity contracts owned by a governmental retirement plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities; and

      (3) Unallocated annuity account ~~which~~ that includes contracts ~~qualified~~ owned by a governmental retirement benefit plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code.

   b. The health insurance account.

2. The association shall come under the immediate supervision of the commissioner ~~of~~ insurance and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

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

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

1. If a member insurer is an impaired ~~domestic~~ insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner~~, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer~~:

   a. Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

b. Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision a and assume payment of the contractual obligations of the impaired insurer pending action under subdivision a; or.

c. Loan money to the impaired insurer.

2. a. If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then, subject to the preconditions specified in subdivision b, the association shall, in its discretion, either:

(1) Take any of the actions specified in subsection 1, subject to the conditions therein; or

(2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

b. The association is subject to the requirements of subdivision a only if:

(1) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(a) The delinquency proceeding shall not be dismissed;

(b) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and

(c) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(2) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(3) If the impaired insurer is a foreign or alien insurer,

(a) It has been prohibited from soliciting or accepting new business in this state;

~~(b) Its certificate of authority has been suspended or revoked in this state;~~

~~(c) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.~~

~~3.~~ If a member insurer is an insolvent insurer, the association ~~shall~~, in its discretion, either shall:

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

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

(2) Assure payment of the contractual obligations of the insolvent insurer; ~~and~~

~~(3) Provide such moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties;~~ or

b. ~~With respect only to life and health insurance policies, provide~~ Provide benefits and coverage in accordance with ~~subsection 4.~~ the following provisions:

~~4. When proceeding under paragraph 2 of subdivision a of subsection 2 or subdivision b of subsection 3, the association shall, with respect to only life and health insurance policies:~~

~~a.~~ (1) ~~Assure~~ With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

~~(1)~~ (a) With respect to group policies and contracts, not later than the earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies and contracts.

~~(2)~~ (b) With respect to ~~individual~~ nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under such policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies or contracts.

~~b.~~ (2) Make diligent efforts to provide all known insureds or ~~group policyholders~~ annuitants for nongroup policies and contracts, or group policyowners with respect to group policies and

contracts, thirty days' notice of the termination of the benefits provided.

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

~~d.~~ (a) In providing the substitute coverage required under ~~subdivision e~~ this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

~~(1)~~ (b) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

~~(2)~~ (c) The association may reinsure any alternative or reissued policy.

~~e.~~ (4) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types of future issuance without regard to any particular impairment or insolvency.

~~f.~~ (5) Alternative policies must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy was last underwritten.

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

~~h.~~ (7) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium must be set by the association

in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the ~~commissioner or by a court of competent jurisdiction~~ domiciliary insurance commissioner and the receivership court.

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

~~5.~~ 3. When proceeding under ~~subdivision b of~~ subsection 2 ~~or subsection 3~~ with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision c of subsection 3 of section 26.1-38.1-01.

~~6.~~ 4. Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract of substitute coverage terminates the association's obligations under such policy or coverage under this chapter with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

~~7.~~ 5. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contractowners arising after the entry of such order.

~~8.~~ 6. The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

~~9.~~ 7. In carrying out its duties under s~~ubsections~~ subsection 2 ~~and 3~~, the association may~~, subject to approval by the court~~:

a. ~~Impose~~ Subject to approval by a court in this state, impose permanent policy or contract liens in connection with any guarantee assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest.

b. ~~Impose~~ Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral or cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in

conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

8. A deposit in this state, held according to law or as required by the commissioner for the benefits of creditors, including policyowners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, under section 26.1-06.1-50, must be paid promptly to the association. The association may retain a portion of any amount received equal to the percentage determined by dividing the aggregate amount of policyowners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policyowners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and retained pursuant to this subsection. Any amount paid to the association less the amount retained by it is treated as a distribution of estate assets pursuant to section 26.1-06.1-43 or similar provision of the state of domicile of the impaired or insolvent insurer.

~~10.~~ 9. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in s~~ubsections~~ subsection 2~~, 3, and 4~~, the commissioner shall have the powers and duties of the association under this chapter with respect to ~~impaired or~~ insolvent insurers.

~~11.~~ 10. The association may render assistance and advice to the commissioner, upon request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

~~12.~~ 11. The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over ~~a third party~~ any person or property against whom the association may have rights through subrogation ~~of the insurer's policyholders~~ or otherwise.

~~13.~~ 12. Any person receiving benefits under this chapter must be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to,

the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contractowner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon such person.

~~14.~~ 13. The subrogation rights of the association under this section have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

~~15.~~ 14. In addition to subsections ~~13~~ 12 and ~~14~~ 13, the association shall have all common-law rights of subrogation and other equitable or legal remedy ~~which~~ that would have been available to the impaired or insolvent insurer or ~~holder~~ owner, beneficiary, or payee of a policy or contract with respect to such policy or contract, including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from or payment for the personal injury relating to the annuity.

15. If subsections 12, 13, and 14 are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or portion of the policies covered by the association. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or portion of the policies covered by the association.

16. ~~The~~ In addition to any other rights and powers under this chapter, the association may:

a. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

b. Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 26.1-38.1-06 and to settle claims or potential claims against it;

c. Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

d. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

e. Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims; ~~and~~

f. Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the power of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

g. Organize itself as a corporation or in other legal form permitted by the laws of this state;

h. Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person promptly shall comply with the request; and

i. Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

17. The association may join an organization of one or more state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

18. At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of the member insurer which accrue on or after this coverage date and which relate to contracts covered in whole or in part by the association under any indemnity reinsurance agreement entered by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer previously and expressly has disaffirmed the reinsurance agreement. The election is effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers. If the association makes an election, subdivisions a through d apply with respect to the agreements selected by the association.

a. The association is responsible for all unpaid premiums due under the agreements, for periods both before and after the coverage date, and is responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered, in whole or in part, by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.

b. The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part, provided that, upon receipt of any of these amounts, the association is obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of

the amount received by the association, over the benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event.

c. Within thirty days following the association's election,the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to every item paid by the member insurer or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. The association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of the aforementioned calculation. If the receiver, rehabilitator, or liquidator received any amounts due the association pursuant to subdivision b, the receiver, rehabilitator, or liquidator shall remit the amounts to the association as promptly as practicable.

d. If the association, within sixty days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer may not terminate the reinsurance agreements, to the extent the agreements relate to contracts covered by the association, in whole or in part, and may not set off any unpaid premium due for periods before the coverage date against amounts due the association.

18. If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subsection 17 effective as of the date agreed by the association and the other insurer and regardless of whether the association made the election, provided that:

a. The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

b. The obligations described in the proviso to subdivision b of subsection 17 no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third-party insurer; and

c. Subsection 18 does not apply if the association previously expressly determined in writing that it will not exercise the election referred to in subsection 17.

19. Subsections 17 and 18 supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator remains entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods before the coverage date, subject to applicable setoff provisions.

20. Except as otherwise expressly provided in this section, this section does not alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. This section does not abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This section does not give a policyowner or beneficiary an independent claim for relief against an indemnity reinsurer which is not otherwise set forth in the indemnity reinsurance agreement.

21. The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

22. If the association arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

23. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

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

26.1-38.1-06. Assessments.

1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments must be due not less than thirty days after prior written notice to the member insurers and must accrue interest at eighteen percent per annum on and after the due date.

2. There must be two classes of assessment, as follows:

   a. Class A assessments must be ~~made~~ authorized and called for the purpose of meeting administrative and legal costs and other expenses ~~and examinations conducted under the authority of section 26.1-38.1-09~~. Class A assessments may be ~~made~~ authorized and called whether or not related to a particular impaired or insolvent insurer.

   b. Class B assessments must be ~~made~~ authorized and called to the extent necessary to carry out the powers and duties of the association with regard to an impaired or insolvent insurer.

3. The amount of any class A assessment must be determined by the board and may be ~~made~~ authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. ~~A~~ The total of all non-pro rata a~~ssessment~~ assessments may not exceed one hundred fifty dollars per member insurer in any one calendar year.

4. The amount of any class B assessment must be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

5. Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became ~~impaired or~~ insolvent or, ~~as~~ in the case ~~may be~~ of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

6. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be ~~made~~ authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection 2 and computation of assessments under this ~~subsection~~ section must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

7. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral are removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

8. a. ~~The~~ Subject to subdivision b, the total of all assessments ~~upon~~ authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for ~~each subaccount thereunder may~~ the health account may not in any one calendar year exceed two percent ~~and for the health account may not in any one calendar year exceed two percent of such insurer's average~~ of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. ~~If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this chapter.~~

b. If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision a must be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

c. If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon after as permitted under this chapter.

9. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

10. If ~~a one percent~~ the maximum assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection ~~4~~ 7, the board shall assess ~~all~~ the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection 8.

11. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future l~~osses~~ claims.

12. It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

13. The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

14. a. A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made

under protest and must set forth a brief statement of the grounds for the protest.

b. Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

c. Within thirty days after a final decision was made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

d. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

e. If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member insurer.

15. The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall comply promptly with a request.

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

5. The plan of operation may provide that any or all powers and duties of the association, except those under subdivision c of subsection ~~15~~ 16 of section 26.1-38.1-05 and section 26.1-38.1-06, are delegated to a corporation, limited liability company, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, limited liability company, association, or organization must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, limited liability company, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

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

3. Any final action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the member's receipt of notice of the final action being appealed. ~~If a member company is appealing an assessment, the amount assessed must be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member company.~~ Any final

action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state which apply to the action or orders of the commissioner.

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

26.1-38.1-09. Prevention of insolvencies.

1. To aid in the detection and prevention of insurer insolvencies or impairments, it is the duty of the commissioner:

~~1.~~ a. To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:

~~a.~~ (1) Revokes its license;

~~b.~~ (2) Suspends its license; or

~~c.~~ (3) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of ~~policyholders~~ policyowners or creditors.

(4) Such notice must be mailed to all commissioners within thirty days following the action taken or the date on which such action occurs.

~~2.~~ b. To report to the board of directors when the commissioner has taken any of the actions set forth in ~~subsection 1~~ subdivision a or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors must contain all significant details of the action taken or the report received from another commissioner.

~~3.~~ c. To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member ~~company~~ insurer that such ~~company~~ insurer may be an impaired or insolvent insurer.

~~4.~~ d. To furnish to the board of directors the national association of insurance commissioners insurance regulation information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein must be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

~~5.~~ 2. The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member

insurers and companies seeking admission to transact insurance business in this state.

~~6.~~ 3. The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations may not be considered public documents.

~~7.~~ 4. ~~It is the duty of the~~ The board of directors, upon majority vote, ~~to~~ may notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

~~8. The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination must be paid by the association and the examination report must be treated as are other examination reports. In no event may such examination report be released to the board of directors prior to its release to the public, but this does not preclude the commissioner from complying with subsection 1.~~

~~The commissioner shall notify the board of directors when the examination is completed. The request for an examination must be kept on file by the commissioner but it may not be open to public inspection prior to the release of the examination report to the public.~~

~~9.~~ 5. The board of directors ~~may~~, upon majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

~~10. The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer and may adopt by reference any report prepared by such other associations.~~

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

26.1-38.1-10. Credits for assessments paid.

1. A member insurer may offset against its premium tax liability to this state an assessment described in ~~subsection 13 of~~ section 26.1-38.1-06 to the extent of twenty percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business,

all uncredited assessments may be credited against its premiums tax liability for the year it ceases doing business.

2. Any sums which are acquired by refund, pursuant to ~~subsection 11 of~~ section 26.1-38.1-06, from the association by member insurers, and which have theretofore been offset against premium taxes as provided in subsection 1, must be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

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

26.1-38.1-11. Miscellaneous provisions.

1. ~~Nothing in this~~ This chapter ~~may be construed to~~ does not reduce the liability for unpaid assessments of the insured of an impaired or insolvent insurer operating under a plan with assessment liability.

2. Records must be kept of all ~~negotiations and meetings in which the association or its representatives are involved~~ meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 26.1-38.1-05. ~~Records of such negotiations or meetings may be made public only upon~~ The records of the association with respect to an impaired or insolvent insurer may not be disclosed before the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the association to render a report of its activities under section 26.1-38.1-12.

3. For the purpose of carrying out its obligations under this chapter, the association must be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subsections 12, 13, and 14~~, and 15~~ of section 26.1-38.1-05. Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue as covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

4. As a creditor of the impaired or insolvent insurer as established in subsection 3 and consistent with chapter 26.1-06, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator, within one hundred twenty days of a final determination of insolvency of an insurer by the receivership court, does not apply to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association is entitled to apply

to the receivership court for approval of its own proposal to disburse these assets.

5. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, any policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In making such a determination, consideration must be given to the welfare of the ~~policyholders~~ policyowners of the continuing or successor insurer.

~~5.~~ 6. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 26.1-38.1-05 with respect to such insurer have been fully recovered by the association.

~~6.~~ 7. If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under ~~such~~ the order has the right to recover on behalf of the insurer, from any affiliate that controlled its capital stock, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections 7, 8, and 9.

~~7.~~ 8. No such distribution ~~shall be~~ is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

~~8.~~ 9. Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared is liable up to the amount of distributions the person would have received if ~~they~~ payment had been ~~paid~~ made immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

~~9.~~ 10. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

~~10.~~ 11. If any person liable under subsection ~~7~~ 8 is insolvent, all its affiliates that controlled it at the time the distribution was paid, are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

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

26.1-38.1-12. Examination of the association - Annual report. The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one

hundred twenty days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

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

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

1. No person, including an insurer, agent, or affiliate of an insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by ~~the North Dakota Life and Health Insurance Guaranty Association Act~~ chapter 26.1-38.1. Provided, however, that this section does not apply to the North Dakota life and health insurance guaranty association or any other entity ~~which~~ that does not sell or solicit insurance.

2. ~~Within one hundred eighty days after July 1, 1989~~ Before January 1, 1990, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with subsection 3. This document should be submitted to the commissioner for approval. Sixty days after receiving ~~such~~ approval, no insurer may deliver a policy or contract ~~described in subsection 2 of section 26.1-38.1-01~~ to a ~~policyholder or contractholder~~ policy or contractowners unless the summary document is delivered to the ~~policyholder or contractholder~~ policy or contractowner to or at the time of delivery of the policy or contract ~~except if subsection 4 applies~~. The document should also be available upon request by a ~~policyholder~~ policyowner. The distribution, delivery, or contents or interpretation of this document does not mean that either the policy or contract or the ~~holder~~ owner thereof would be covered in the event of the impairment or insolvency of a member insurer. The document must be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the ~~policyholder~~ policyowner, ~~contractholder~~ contractowner, certificate holder, or insured any greater rights than those stated in this chapter.

3. The document prepared under subsection 2 must contain a clear and conspicuous disclaimer on its face. The commissioner shall ~~adopt a rule establishing~~ establish the form and content of the disclaimer. The disclaimer must:

   a. State the name and address of the life and health insurance guaranty association and insurance department;

   b. Prominently warn the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner that the North Dakota life and health guaranty

association may not cover the policy, or, if coverage is available, it will be subject to substantial limitations and exclusions and be conditioned on continued residence in this state;

c. State the types of policies for which guaranty funds will provide coverage;

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

~~d.~~ e. Emphasize that the ~~policyholder~~ policyowner or ~~contractholder~~ contractowner should not rely on coverage under the North Dakota life and health guaranty association when selecting an insurer; ~~and~~

f. Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

~~e.~~ g. Provide other information as directed by the commissioner, including sources for information about the financial condition of insurers provided the information is not proprietary and is subject to disclosure under the state's public records law.

4. ~~No insurer or agent may deliver a policy or contract described in subsection 2 of section 26.1-38.1-01 and excluded under subdivision a of subsection 3 of section 26.1-38.1-01 from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policyholder or contractholder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the North Dakota life and health guaranty association. The commissioner shall by rule specify the form and content of the notice.~~ A member insurer shall return evidence of compliance with subsection 2 for so long as the policy or contract for which the notice is given remains in effect.

Approved March 3, 1999
Filed March 4, 1999

CHAPTER 272

HOUSE BILL NO. 1202
(Representative Wald)

DOMESTIC VIOLENCE INSURANCE TREATMENT

AN ACT to create and enact a new section to chapter 26.1-39 of the North Dakota Century Code, relating to property and casualty insurance treatment of domestic violence.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-39 of the North Dakota Century Code is created and enacted as follows:

Domestic violence - Intentional acts. An insurer issuing or renewing a policy of property and casualty insurance in this state may not base any rating, underwriting, or claim handling decision solely on whether an applicant or insured suffers from domestic violence as defined under chapter 14-07.1. If a property and casualty insurance policy excludes property coverage for intentional acts, the insurer may not deny payment to an innocent coinsured who did not cooperate in or contribute to the creation of the loss if the loss arose out of domestic violence and the perpetrator of the loss is criminally prosecuted for the act causing the loss. Payment to this innocent coinsured may be limited to the innocent coinsured's ownership interest in the property as reduced by any payment to a mortgagor or other secured interest.

Approved March 8, 1999
Filed March 8, 1999

CHAPTER 273

SENATE BILL NO. 2376

(Senators Cook, Christmann)
(Representatives Grosz, Keiser)

NONECONOMIC LOSS FOR BODILY INJURY

AN ACT to create and enact a new section to chapter 26.1-41 of the North Dakota Century Code, relating to noneconomic loss for serious, accidental bodily injury; to provide for a report to the legislative council; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-41 of the North Dakota Century Code is created and enacted as follows:

Secured person exemption for no liability insurance. In any action against a secured person to recover damages because of accidental bodily injury arising out of the ownership or operation of a secured motor vehicle in this state, the secured person may not be assessed damages for noneconomic loss for a serious injury in favor of a party who has at least two convictions under section 39-08-20 and who was operating a motor vehicle owned by that party at the time of injury without a valid policy of liability insurance in order to respond to damages for liability arising out of the ownership, maintenance, or use of that motor vehicle.

SECTION 2. REPORT TO LEGISLATIVE COUNCIL. In 2002, the director of the department of transportation shall report to an interim committee designated by the legislative council regarding the effectiveness of section 1 of this Act in decreasing the incidents of driving without liability insurance.

SECTION 3. EXPIRATION DATE. This Act is effective through July 31, 2003, and after that date is ineffective.

Approved March 15, 1999
Filed March 15, 1999

CHAPTER 274

SENATE BILL NO. 2046

(Legislative Council)
(Insurance and Health Care Committee)

PARTNERSHIP FOR LONG-TERM CARE PROGRAM REPEAL

AN ACT to repeal chapter 26.1-45.1 of the North Dakota Century Code, relating to the partnership for long-term care program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. REPEAL. Chapter 26.1-45.1 of the North Dakota Century Code is repealed.

Approved March 4, 1999
Filed March 4, 1999

CHAPTER 275

HOUSE BILL NO. 1104

(Industry, Business and Labor Committee)
(At the request of the Bank of North Dakota)

LOW-RISK INCENTIVE FUND LOAN PARTICIPATION

AN ACT to amend and reenact section 26.1-50-03 of the North Dakota Century Code, relating to Bank of North Dakota participation in loans made by the low-risk incentive fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-50-03 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

26.1-50-03. North Dakota low-risk incentive fund use. The fund may be used only for making loans to low-risk businesses for primary sector business projects in this state ~~and no~~. A loan may not be approved or made by the fund without ~~a ten percent~~ some participation in the a~~ggregate amount of the~~ loan by the Bank of North Dakota. ~~The participation of the Bank of North Dakota in a loan may not exceed ten percent of the aggregate amount of the loan.~~ A loan from the fund may not be made to an insurer. The governing board shall establish the rate of interest and terms of repayment for a loan from the fund. Fifty percent of the amount loaned from the fund during the first year of a biennium must be reserved solely for businesses in rural areas. The remainder loaned from the fund may be used in urban or rural areas. For purposes of this section, "rural areas" means the area of the state not including territory within the corporate limits of a city with a population of twenty thousand or more.

Approved March 16, 1999
Filed March 16, 1999

CHAPTER 276

HOUSE BILL NO. 1255

(Representatives Wald, Berg, Porter)
(Senators Klein, Mutch, Tallackson)

SELF-CRITICAL INSURANCE ANALYSIS PRIVILEGE

AN ACT to provide a self-critical insurance analysis privilege.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. In this Act, unless the context or subject matter otherwise requires:

1. "Commissioner" means the insurance commissioner.

2. "Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance with, laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of an insurer licensed or regulated under title 26.1, or which involves an activity regulated under title 26.1.

3. "Insurance compliance self-critical analysis audit document" means a document prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-critical analysis audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-critical analysis audit document may include, as applicable, field notes and records of observations, workpapers, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-critical analysis audit document also includes:

   a. An insurance compliance audit report prepared by an auditor, who may be an employee of the insurer or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

   b. Memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

   c. An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

   d. Analytic data generated in the course of conducting the insurance compliance audit.

4. "Insurer" means an insurance company, nonprofit service corporation, or health maintenance organization organized under the laws of this state or a foreign insurance company, nonprofit service corporation, or health maintenance organization authorized to do business in this state.

SECTION 2. Self-critical analysis privilege created - Scope. An insurance compliance self-critical analysis privilege is created to protect the confidentiality of insurance compliance self-critical analysis documents or communications in regard to their content relating to voluntary internal compliance audits conducted by insurers and persons in regard to activities regulated under title 26.1, both to conduct voluntary internal audits of its compliance programs and management systems, and to assess and improve compliance with state and federal statutes, rules, and orders. The insurance compliance self-critical analysis privilege applies to all litigation or administrative proceedings pending on the effective date of this Act.

SECTION 3. Insurance compliance self-critical analysis document not discoverable or admissible. Except as provided in sections 5, 6, and 7 of this Act, an insurance compliance self-critical analysis audit document is privileged information and is not discoverable or admissible evidence in any legal action in any civil, criminal, or administrative proceeding. The privilege is a matter of substantive law of this state and is not merely a procedural matter governing administrative, civil, or criminal procedures in the courts of this state.

SECTION 4. Application of privilege. If an insurer, person, or entity performs or directs the performance of an insurance compliance audit, an officer, employee, or agent involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, may not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-critical analysis audit document. This section does not apply if it is determined under section 6 or 7 that the privilege does not apply.

SECTION 5. Submission to commissioner.

1. Upon request of the commissioner, an insurer must submit an insurance compliance self-critical analysis audit document to the commissioner, or the commissioner's designee, as a confidential document under the provisions of section 26.1-03-19.4 without waiving the privilege set forth in this Act to which the insurer would otherwise be entitled. However, the provisions of sections 26.1-03-19.3 and 26.1-03-19.4 permitting the commissioner to make confidential documents public and accessible to the national association of insurance commissioners does not apply to the insurance compliance self-critical analysis audit documents voluntarily submitted. To the extent the commissioner has the authority to compel the disclosure of an insurance compliance self-critical analysis audit document under other provisions of applicable law, any report furnished to the commissioner may not be provided to any other person or entity and must be accorded the same confidentiality and other protections as provided above for voluntarily submitted documents. Any use of an insurance compliance self-critical analysis audit document furnished as a result of a request of the commissioner, whether under a claim of authority to compel disclosure or not, is limited to determining whether any disclosed defects in an insurer's policies or procedures or inappropriate treatment of customers has been remedied or that an appropriate plan for their remedy is in place. The commissioner may not impose any type of administrative fine or penalty as to any area

addressed or matter covered in an insurance compliance self-critical analysis audit document furnished at the commissioner's request, except where there is clear and convincing evidence that the insurer failed to undertake reasonable corrective action, eliminate inappropriate treatment of customers, or failed to implement an appropriate plan to rectify any noncompliance with state and federal statutes, rules, and orders.

2. An insurer's insurance compliance self-critical analysis audit document submitted to the commissioner remains subject to all applicable statutory or common law privileges including the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion. An insurance compliance self-critical analysis audit document submitted to and in the possession of the commissioner remains the property of the insurer and is not subject to any disclosure or production under section 44-04-18.

3. Disclosure of an insurance compliance self-critical analysis audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, does not constitute a waiver of the privilege with respect to any other person or any other government agency.

SECTION 6. Waiver of privilege by insurer - Grounds for determination of privilege - Civil, administrative, or criminal proceedings.

1. The self-critical analysis privilege does not apply to the extent that it is expressly waived by the insurer that prepared or caused to be prepared the insurance compliance self-critical analysis audit document.

2. In a civil or administrative proceeding, a court of record, after an in-camera review, may require disclosure of material for which the privilege is asserted, if the court determines one of the following:

   a. The privilege is asserted for a fraudulent purpose; or

   b. The material is not subject to the privilege.

3. In a criminal proceeding, a court of record, after an in-camera review, may require disclosure of material for which the privilege is asserted, if the court determines one of the following:

   a. The privilege is asserted for a fraudulent purpose;

   b. The material is not subject to the privilege; or

   c. The material contains evidence relevant to commission of a criminal offense, and all three of the following factors are present:

      (1) The commissioner, state's attorney, or attorney general has a compelling need for the information;

      (2) The information is not otherwise available; and

      (3) The commissioner, state's attorney, or attorney general is unable to obtain the substantial equivalent of the information

by any other means without incurring unreasonable cost and delay.

SECTION 7. Determination of privilege - Procedure.

1. If a person seeks from an insurer communications involving an insurance compliance audit or any insurance compliance self-critical analysis audit document during the course of a pending civil or criminal proceeding, the insurer may assert the self-critical analysis privilege and provide the information set forth in subsection 6 during the course of those proceedings just as any other privilege is asserted in the courts of this state. If the court is required to make a determination as to the privilege, the court shall follow the procedure and conditions set forth in subsection 5.

2. If there is a pending administrative proceeding, or there is no pending civil or criminal proceeding, the commissioner, state's attorney, or attorney general may serve on an insurer a written request by certified mail for disclosure of an insurance compliance self-critical analysis audit document. Within thirty days after the commissioner, state's attorney, or attorney general serves on an insurer a written request by certified mail for disclosure of an insurance compliance self-critical analysis audit document, the insurer that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in-camera hearing on whether the insurance compliance self-critical analysis audit document or portions of the document are privileged under this Act or subject to disclosure. The court has jurisdiction over a petition filed by an insurer under this subsection requesting an in-camera hearing on whether the insurance compliance self-critical analysis document or portions of the document are privileged or subject to disclosure. Failure by the insurer to file a petition waives the privilege for only the specific request made.

3. An insurer asserting the insurance compliance self-critical analysis privilege in response to a request for disclosure under this section shall include in its request for an in-camera hearing all of the information set forth in subsection 6.

4. Upon the filing of a petition under this section, the court shall issue an order scheduling, within forty-five days after the filing of the petition, an in-camera hearing to determine whether the insurance compliance self-critical analysis audit document or portions of the document are privileged under this Act or subject to disclosure.

5. The court, after an in-camera review, may require disclosure of material for which the privilege is asserted if the court determines, based upon its in-camera review, that any one of the conditions set forth in subsection 2 of section 6 of this Act is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in subsection 3 of section 6 of this Act is applicable as to a criminal proceeding. Upon making such determination, the court may only compel the disclosure of those portions of an insurance compliance self-critical analysis document relevant to issues in dispute in the underlying proceeding. A compelled disclosure may not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. An insurer unsuccessfully opposing

disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

6. An insurer asserting the insurance compliance self-critical analysis privilege in response to a request for disclosure under this section shall provide at the time of making and filing any objection to the disclosure all of the following information:

   a. The date of the insurance compliance self-critical analysis audit document.

   b. The identity of the entity conducting the audit;

   c. The general nature of the activities covered by the insurance compliance audit; and

   d. An identification of the portions of the insurance compliance self-critical analysis audit document for which the privilege is being asserted.

SECTION 8. Privilege - Burden of proof - Stipulation. An insurer asserting the insurance compliance self-critical analysis privilege set forth in this Act has the burden of demonstrating the applicability of the privilege. Once an insurer has established the applicability of the privilege, a party seeking disclosure has the burden of proving that the privilege is asserted for a fraudulent purpose. The commissioner, state's attorney, or attorney general seeking disclosure of the privilege has the burden of proving the elements set forth in subdivisions a and c of subsection 3 of section 6 of this Act.

The parties may at any time stipulate in proceedings under section 6 or 7 of this Act to entry of an order directing whether the specific information contained in an insurance compliance self-critical analysis audit document is or is not subject to the privilege provided under this Act. Any such stipulation may be limited to the instant proceeding and, absent specific language to the contrary, is not applicable to any other proceeding.

SECTION 9. Nonapplication of privilege. The self-critical analysis privilege set forth in this Act does not extend to:

1. Documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency pursuant to title 26.1, or other federal or state law;

2. Information obtained by observation or monitoring by any regulatory agency; or

3. Information obtained from a source independent of the insurance compliance audit.

Approved March 29, 1999
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